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OVERVIEW OF MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

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OVERVIEW OF MEDICARE PROGRAM

FRIDAY, MARCH 3, 1989

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in Room SD-215, Dirksen Senate Office Building, the Honorable John D. Rockefeller, IV (chairman) presiding.

Present: Senators Rockefeller, Baucus, Daschle, Danforth and Heinz.

[The prepared statements of Senators Bentsen, Heinz, Pryor and Rockefeller appear in the appendix.]

[The press release announcing the hearing follows:]

[Press Release No. H-9, February 24, 1989]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON OVERVIEW OF MEDICARE PROGRAM

WASHINGTON, DC—Senator John D. Rockefeller IV, (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long-Term Care, announced today that the Subcommittee will hold a hearing to look at the current status of the Medicare program, how it has evolved, and suggestions for future improvements.

The hearing is scheduled for *Friday, March 3, 1989 at 10 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

In announcing the hearing, Chairman Rockefeller said, "The increase in the number of elderly, rising Medicare spending, changes in health care delivery systems and hospital reimbursement policies, and the lack of a national policy on long-term care highligth the need to examine how the Medicare program is working and responding to the needs of the elderly and disabled. The first hearing of the new Subcommittee on Medicare and Long-Term Care will examine the current health care environment, explore new ideas, and provide the framework for future discussion of the Medicare program."

STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Good morning.

I wonder if the witnesses could come forward, please.

We welcome everyone here today, not only our witnesses but others. Most of you have been here before as witnesses and I have had a chance in my few short years on this committee to listen to some of your views and to ask you questions.

I really want to emphasize the fact that we are a different committee now—a different subcommittee. The former Health Committee is now made up of two subcommittees. The one which I chair, which I am very honored and very happy and intellectually and emotionally pleased to be able to do that.

This committee is the Committee on Medicare and Long-Term Health Care. The other subcommittee of the former Health Committee is chaired by Don Riegle, it deals with Medicaid and the Uninsured In a sense, I guess you could say this is our first subcommittee hearing ever. I am pleased about that.

Dave Durenberger, who will be here, will be the ranking minority member. I am very pleased about that because I think Dave Durenberger is a real champion of the Medicare program and I know he cares enormously about quality. He cares, obviously, about rural health care, but also represents urban interests, too. I think we are going to have an interesting subcommittee.

You have to obviously help us. As a subcommittee, we watch over an incredible Federal program which is understood by few. We spend an enormous amount of money for the Medicare program. I look on this meeting this morning as a forum. In fact, I think our subcommittee ought to be a forum—a bold, aggressive, sometimes dramatic, contentious forum for putting ideas out so that we can explore various aspects of the Medicare program.

How is Medicare working—it has been asked before, but it can never be answered enough. Has it adapted to the changing conditions of today's elderly? What about the trend of Medicare spending?

Incidentally, this is not to be a discussion about budget cuts today. That is for another day, another time. I think this should be about Medicare as a program and its various qualities. Containing costs is obviously on the minds of all of show can that be done? Can it be done? And in all cases, can it be done safely? How do we make sure that the elderly receive the care that they need when they need it, where they need it and in an appropriate setting? What are the key issues to consider in trying to bring about long-term health care coverage?

That is obviously going to be the next battle front. There is some feedback about catastrophic, obviously, because those who paid more than the $4 premium are letting us hear about it. And many who are paying the $4 premium are letting us hear about it. And, therefore, there is something of a sense of wonder or worry. I have been approached by a number of persons asking if we are going to change catastrophic and I, reflecting not only my own views but always importantly this committee is, and the chairman's views say, no, we are not going to.

When Medicare was first enacted there were a lot of complaints about that. There were also complaints when Social Security was first started and money was deducted automatically from various checks. I would hope that in future years that there would be an understanding that the catastrophic legislation provides coverage for all elderly, and for it to be available to everyone, it has to be paid for by all senior citizens.

In any event, that has had a lot of ripples around these series of buildings and you know that. You know, we made a commitment to the elderly through the Social Security Act. I think it is understood to be a substantial one. The middle 1960s commitment to the Medicare Act in line with the Social Security Act, that was a major, commitment to our senior population. I think most people would agree that those two programs combined have on a net basis left

this generation of seniors better off than the last. But on the other hand, that is academic in a sense too because people do not usually compare themselves to what the situation was 20 years ago. They compare their situation to what it is they would like their situation to be in a perfect world, and that is human nature.

So in essence, I really want all of us to think big today, both the panel and us. I want to hear, in fact, even what is good about Medicare. There is nothing wrong with talking about that. And also to be reminded of what must be preserved. I would know that all of you have visions for Medicare, what you would like to see in a perfect world. I would like to hear even some of your wilder thoughts, your provocative thoughts.

On the other hand, as you give those, we all have to be disciplined, I think, by the fact that we do have a budget deficit. I do not know how Congress is going to respond to that this year but I am not prepared to climb to the mountain top in terms of a courageous approach. We will do what we have to do. We keep avoiding the day of the final judgment and the problems of our nation's elderly pushes us to do that. Because, we want to help; we do not want to hurt; we do not want to restrict. And at some point, you have done about all you can and then you have to deal with the budget more realistically than we are apparently doing.

So in any event, what needs immediate attention; what specific issues do you think we should be focusing on this year? You are an extraordinary committee mean, a pane land you have many ideas long-term care, uninsured, lots of subjects to cover. So I will adhere this morning to the five-minute rule. You have all been here before, you are practiced at that. It is benign, but ruthlessly enforced. So try to give your statements in five minutes. And I would ask, incident, that as we go along that you bounce off of each other intellectually and in ideas. Do not just respond to us, argue amongst yourselves.

Dr. Young, would you like to start.

Dr. YOUNG. Thank you, Mr. Chairman.

I am pleased to be—

Senator ROCKEFELLER. Also, there may be statements that others wish to make. I clearly have made my first error.

So, Senator Heinz.

STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. I first want to commend you on holding this hearing. It has been my privilege to see before this committee and the aging committee many of our witnesses today and they are, indeed expert.

I would ask that my entire statement be put in the record. I cannot help but observe that only one of the reasons that we are here is to address the fact that the Medicare program continues to experience very high cost increases in both part A and part B. In addition to looking at how we control the runaway costs of part B and how we explain the increase in volume and utilization that seems to be well beyond our control, we must also take note of the fact that when we implemented Ergs back in 1983, an implementa-

tion that has had the effect of considerable savings to part A, our biggest concern was the departure out the hospital back door of patients sicker and quicker.

We paid a lot of attention to this problem and, for the most part, have been able to maintain a reasonable quality in the delivery of care at the hospital level. We have also apparently avoided and it was not easy, and some people did fall through the cracks the discharge of people into inappropriate levels of care.

Now we are finding under Ergs and perhaps certainly the more so, in my judgment, if we accept the Administration's part A proposal, that it will be impossible for people to get in the front door because hospitals will not be there when they arrive. Some 150 hospitals have closed since DRGs went into effect. Eighty-one of them—more than half—closed last year, including two in my own State. There are another 600 hospitals, we are told, that will go into bankruptcy if the financial constraints that have been imposed upon them are not eased. In my own State of Pennsylvania, preliminary survey findings show that at least 31 percent of our hospitals are experiencing net operating losses.

Mr. Chairman, we have a tiger by the tail here. We have a very tough row to hoe. It is going to take absolutely the best brain power in this country to be able to solve some of the runaway cost problems and still maintain access to health care as we believe it to be required in this country. So I commend you, once again, for this investigation of what we might do constructively.

Senator ROCKEFELLER. Thank you, Senator Heinz.

Senator Danforth, do you have any comments?

Senator DANFORTH. I have no questions at this time, Mr. Chairman.

Senator ROCKEFELLER. Dr. Young.

STATEMENT OF DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; WASHINGTON, DC

Dr. YOUNG. Thank you, Mr. Chairman.

I am pleased to be here this morning to discuss Medicare part A and especially the Medicare prospective payment system. Despite cost containment efforts in recent years, the rate of increase in total health care spending for our Nation continues unchanged in the past ten years. This growth is displayed in Exhibit 1.

For the Medicare program, however, there are major changes during the PPS years in the pattern of spending. Exhibit 2 shows that when you control for inflation and you control for the growth of the Medicare population, there has been a substantial decrease in the rate of growth of in-patient hospital spending.

In addition, total Medicare spending, which was growing at a rate of more than 8 percent a year, is now growing 4 percent a year, after you remove the effects of inflation and Medicare enrollee growth.

Other Medicare expenditures, especially for physician and outpatient hospital services, continue to grow at an average annual rate of 10 percent above inflation and above increases in Medicare enrollment.

A major factor in the decline in hospital expenditures was the dramatic decrease in hospital admissions beginning in 1983. As you can see in Exhibit 3, however, admissions are again rising.

Exhibits 4 and 5 show the other major reason for the decrease in Medicare expenditures and that is the decrease in Medicare per case payments to hospitals. PPS update factors, which are set annually to account for inflation and for other things that effect hospital costs, have been severely constrained in recent years at levels well below the market basket measure of inflation. Nevertheless, PPS payments per case have been much higher than these update factors.

This has occurred because hospitals are reporting and are being paid for the care of a sicker mix of patients. Some of this increase in the mix of cases is really sicker patients but some is simply more complete reporting and does not represent increased costs for the care of sicker patients.

As you can see, while hospital payments per case were very high in the early years of PPS, they have declined sharply since then. In contrast, while hospital operating costs per case increased only 2.2 percent in the first year of PPS, since then cost per case have increased on the average almost 10 percent each year. The result of the constrained Medicare payments and the continued increase in costs is a decrease in hospital margins or hospital profits. This is shown in Exhibit 6.

Hospitals enjoyed very high profits in the first three years of PPS. Since then profits have fallen and the average hospital will experience a loss in 1989.

Finally, however, I need to stress these average figures conceal very significant variations across hospitals. Some hospitals continue to enjoy high profits while others have much greater than average losses and these losses may jeopardize the survival of some hospitals. And, in fact, we are seeing an increased number of hospital closures.

In my prepared testimony I stressed the importance of continuing to examine the PPS payment formula and continuing to make adjustments such as the higher update factors which have been given to rural hospitals. These adjustments are necessary to ensure that Medicare policy and payments are fair to all hospitals.

In conclusion, Mr. Chairman, the PPS years have seen reductions in the increases we were seeing previously in spending for inpatient hospital services. At the same time, however, spending for services outside the hospital continues to grow rapidly. In addition, there continues to be the need for adjustments to ensure the fairness of payments to hospitals.

I would be pleased to answer questions and to comment further on any of these topics during the discussion period.

Thank you.

[The prepared statement of Dr. Young appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Young.

Dr. Karen Davis.

STATEMENT OF KAREN DAVIS, PH.D., CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, THE JOHNS HOPKINS UNIVERSITY SCHOOL OF HYGIENE AND PUBLIC HEALTH, BALTIMORE, MD

Dr. DAVIS. Thank you, Mr. Chairman, for this opportunity to testify on the present problems and challenges facing part B of the Medicare program.

Attention to this part of Medicare is long overdue. As Mr. Young has indicated, Congressional action in recent years has been at least partially successful in slowing hospital expenditures under Medicare, but expenditures for physician and other ambulatory services covered under part B of Medicare have continued to spiral upward.

Part B is financed 75 percent out of general tax revenues and 25 percent by a premium that the elderly and disabled Medicare beneficiaries pay. Therefore, part B is an important part of the overall Federal budget deficit since rising part B outlays have a direct effect upon general tax revenues that are required to meet those outlays.

The premiums are also of concern to the elderly. Not just the new premium from the catastrophic cover, but the fact that with part B going up so rapidly the 25 percent share of that program is paid for by the elderly through their part B premiums has also been rising rapidly.

In fact, Part B outlays are one of the most rapidly increasing components of the Federal budget. They have been going up about 18 percent a year for the last decade. That is faster than the gross national product. It is even faster than the part A outlays. Since in the most recent period we have had increases around 14 percent a year for the last couple of years, CBO projects it will continue to go up at 13 percent a year over the next five years. That is when overall inflation is running 4 or 5 percent, so Part B outlays are expected to grow much faster than overall inflation.

Part B is currently $35 billion. This represents 40 percent of the entire Medicare outlays. By 1994 part B will rise to $80 billion. We will be spending as much on part B alone in 1994 as we are on the entire Medicare program today.

There are several reasons for this rapid increase in part B outlays. One is the increase in the number of older people, and particularly the increasing number of very old people. But, that accounts for only a small fraction of the increase in outlays. Physician fees are rising faster than the consumer price index and I have included a chart in my testimony that demonstrates in the last few that that has been a particular problem.

But about 44 percent of the increase in expenditures can be traced to increases in numbers of services for which physicians are billing under part B. And we really do not know as much about that as we would like to. But we do know that diagnostic testing and bills for ambulatory surgical procedures are among the most rapidly increasing types of services.

Increases in part B are of concern to taxpayers, but they are also of concern to the elderly and disabled beneficiaries who continue to face serious financial hardships in paying for their medical care

bills. Medicare is very important to the elderly and pays a significant fraction of their bills. But despite Medicare, the elderly spent almost $2400, out of pocket, per person on average in 1988 on health care services. Health care expenses paid by the elderly now account for 18 percent of their income, up from about 12 percent ten years ago.

The cost sharing amounts that the elderly pay under part B include the monthly premium a $75 deductible, and 20 percent co-insurance on all allowed charges. In addition, Medicare beneficiaries pay "balance billing" if their physicians charge more than the Medicare program allows. And while the new Medicare Catastrophic Act put a ceiling on the maximum deductible and co-insurance amounts that beneficiaries pay under the program, it did not address balance billing. And many elderly, particularly near poor and very sick beneficiaries, are being hard hit by those balance bills.

It varies a lot, the extent to which physicians charge patients over and above what Medicare allows. Anesthesiology, for example, is the specialty which is least likely to accept assignment and to participate in the Medicare program in terms of agreeing to accept assignment on all claims.

Reform in Medicare part B payment methods for physicians should be a major priority target for reform. Your reform policies must be aimed at achieving the multiple goals of reducing costs, ensuring access to quality care, protecting the financial security beneficiaries and promoting equity in payment to physicians. It should include the institution of a fee schedule with relative values based upon resource costs. But we need to go beyond just looking at the price we pay for services and try to limit unnecessary increases in volume of services. One idea is to link increases in fees to performance on total physician expenditures—a so-called expenditure target.

Finally, we must be concerned with the actual financial burden on the elderly and set limits on any amounts that physicians are permitted to charge over and above what Medicare pays.

Thank you very much.

Senator ROCKEFELLER. Would you repeat your last statement again.

Dr. DAVIS. In addition to being concerned with the set price that Medicare will pay in giving physicians an incentive to control the total volume of services, I believe we need to look at the actual charge of the physician and limit the extent to which a physician can bill patients over and above what Medicare allows.

[The prepared statement of Dr. Karen Davis appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Davis.

Senator Daschle, do you have any opening comments you want to make?

Senator DASCHLE. No, I don't.

Senator ROCKEFELLER. Okay.

Dr. MOON.

STATEMENT OF MARILYN MOON, PH.D., DIRECTOR, PUBLIC POLICY INSTITUTE, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Dr. MOON. Thank you. I am very pleased to be here this morning.

Medicare beneficiaries are very much like health care consumers of all ages. They want high quality health care delivered simply and humanely at the lowest possible cost. The enactment of Medicare in 1965 went a long way to ensure that Americans over age 65 would have access to mainstream medical care at an affordable cost.

Medicare continues to be an enormously popular program that offers much to the aged and disabled persons it serves. Nonetheless, the goals of quality, reasonableness, simplicity and low cost are not always achieved under the Medicare program. It is about those issues that I want to speak this morning in my testimony.

First, the issues of quality and reasonableness can be taken together. There are two reasons why people talk about quality problems in Medicare. First, there is a growing awareness about problems of quality, per se. These are questions of whether care is appropriate, whether it's delivered with high technical skill and so forth. These are not just Medicare issues, they are questions for people of all ages.

I know that my colleague, Kathy Lohr, is likely to talk about this dimension so I will only briefly talk about it this morning.

But quality concerns are also underscored for Medicare, or perhaps made worse for Medicare, because of some of the cost containment efforts that have been undertaken. As has already been mentioned, the issue of quicker/sicker discharges from hospitals is of concern. In addition, providers may limit the time they spend with Medicare beneficiaries if, for example, we clamp down too much on physician reimbursement.

Any cost containment efforts thus need to look very closely at the impact on the quality of care that will be delivered to Medicare beneficiaries. High quality has made Medicare successful thus far.

If you ask beneficiaries about their concerns, they often do not say that they are worried that their doctor does not have high skills, or that he is not concerned about them, but they will often tell you that they are concerned about coverage. This is not truly a quality issue, but it may be a reasonableness issue.

To many older and disabled beneficiaries drawing artificial lines between chronic care and acute care makes little sense. They will cut right to the heart of the problem and say, "this is the care that I need so why is Medicare not covering it?" The same is true in the case of preventive services as well.

So in many ways, Medicare does not always meet the test of reasonableness to beneficiaries when they look at why some things are covered and why other things are not. That can also affect quality of care if providers and beneficiaries try to get around the rules and regulations of the system by distorting the kinds of care used.

Patients also indicate that they want to have choices in health care. This is an important component for meeting the rest of reasonableness as well.

A third major area, in addition to quality and reasonableness, is the question of simplicity. Simplicity is again a topic that you hear beneficiaries talk about over and over again. They do not understand the forms they receive. They do not understand their appeal rights—for example, the rights they have when they are in the hospital. They do not find the system an easy one to deal with.

Certainly I've found that friends who are health care professionals find it difficult to help their parents or relatives work their way through the system, underscoring that this is not an easy system to understand.

We also know that this system in many ways confuses providers. Sometimes provides with good reason and with noble purpose may be mistaken about what is covered and what is not. And in some cases, it appears that the complexity of Medicare is used to the detriment of beneficiaries by providers, perhaps not always in a naive way. For example, beneficiaries are sometimes told that their Medicare days have run out and it is time for them to leave the hospital, although this is not the way the system is supposed to operate.

This is particularly an area where many improvements could be considered that are not necessarily costly. Even in an environment of cost containment, some real good could be done in improving simplicity and clarity of forms, and in offering uniformity of coverage and education.

Finally, let me only talk briefly about cost because both the previous speakers have spoken about that. We know that when we wring our hands about the high costs of Medicare in the current system and how rapidly it is going up, that people often forget that the costs to beneficiaries are rising just as rapidly. Over the period 1980 to 1987, costs rose at almost exactly the same rate per capita for Medicare and for beneficiaries. If you include 1988 when there was an enormous increase in the part B premium, beneficiaries are now beating the Medicare system in terms of their increase in out-of-pocket costs.

Over the period of 1980 to 1987, incomes of older Americans, on average, rose about a third as fast. So increasing costs are obviously a problem for beneficiaries.

[The prepared statement of Dr. Marilyn Moon appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Moon.

Dr. Lohr.

STATEMENT OF KATHLEEN N. LOHR, PH.D., SENIOR PROFESSIONAL ASSOCIATE, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, WASHINGTON, DC

Dr. LOHR. Thank you, Mr. Chairman.

Good morning. I am Kathy Lohr. I am the Director of the study that Congress commissioned in OBRA 1986 to look at longer term strategies for quality assurance in the Medicare program.

The study is being conducted by the Institute of Medicine. Our report is due to you January 1990. Today I would like to highlight five points, which are my personal observations.

First, quality of care in this Nation is good, but we have to keep it that way. In protecting the quality of care for the elderly we pro-

tect it for ourselves, our children, and our children's children. We are working off a solid admirable base. We must not allow it to be eroded.

Second, quality of care, although good, is not uniformly good. It can differ considerably from area to area, beneficiary to beneficiary, doctor to doctor, hospital to hospital. The use of hospital care and of surgical procedures varies considerably, even across small geographic areas, in ways that we cannot fully account for. The effectiveness and the outcomes of care can also vary greatly in ways we cannot easily explain.

These differences can arise from poor technical skills of practitioners, from underuse of needed and appropriate services and from overuse of unnecessary, inappropriate and sometimes risky services and procedures. Understanding the source of such variations and working to reduce them—by, for instance, developing clinical indicators and practice guidelines—should benefit all parties and not just the elderly.

Third, care for the elderly is often fragmented and discontinuous in ways that threaten high quality care. We do not seem to have a rational system for ensuring the continuity or the seamlessness of care across settings and among providers. For the elderly who have multiple, complex, chronic problems, continuity is interrupted when care must be obtained from many different practitioners and specialists, in different and sometimes new and unfamiliar settings, or at home at least partially from family and kin who themselves may be elderly and infirm. Thus, physical and financial access to health care generally—and whether services are covered completely, partially, or not at all by Medicare—are both inextricably linked to the quality of health care for the elderly.

Fourth, trust between patients and doctors is important, and we must keep it alive. There is a growing uneasiness about a perceived erosion of the mutual sense of trust implied by the phrases the "doctor-patient relationship" and the "art of care." The elderly today are uncertain about where the true allegiance of their physicians lies.

The traditional view that physicians should place the interests of the individual patient above all other considerations seems to be slipping away. But physicians and other health care professionals increasingly face truly conflicting influences—their traditional, professional values; malpractice concerns; utilization management in the name of cost containment—and those influences push them ever farther away from their agency role for their patients.

Once gone, that bedrock of trust in physicians will not easily, if ever, be regained. The growing wedge of mistrust between doctor and patient may severely threaten the quality of care enjoyed by this Nation because, when we are sick, to whom should we then turn?

Fifth, quality of care is worth it, and we should be investing in it. Maintaining and improving the quality of health care requires resources. It requires people; it requires reliable and valid assessment instruments; it requires financing. Those resources are in short supply today.

The demand for quality assurance calls for increasingly complex programs, yet we devote very little of the Nation's attention or

wealth to reviewing, assuring, or improving the quality of care that we pay for. And although the art and the science of quality assurance are increasingly sophisticated, we still have little concrete understanding of the best ways to identify poor, or for that matter exemplary, providers, to remove poor providers from practice, to assist providers in improving what they do or to reward providers for superlative performance.

To understand appropriate patterns of service, good processes of care, and expected outcomes of appropriate or necessary care, considerable research on effectiveness and on outcomes is needed. Congress supports the idea that such work such should be undertaken by the Department of Health and Human Services; it will contribute greatly to maintaining and improving the quality of health care received by all, not just the elderly.

To know where quality-related problems exist, to be able to intervene effectively once problems arise or become critical, and to foster attitudes and programs oriented to the continuous improvement of care, we need a similarly larger investment in the study of existing and emerging approaches to quality review and assurance.

Thank you, Mr. Chairman, for the opportunity to appear.

[The prepared statement of Dr. Kathleen N. Lohr appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Lohr.

Lynn Etheredge.

STATEMENT OF LYNN ETHEREDGE, CONSULTANT, CONSOLIDATED CONSULTING GROUP, WASHINGTON, DC

Mr. ETHEREDGE. Thank you, Mr. Chairman.

The Medicare program's payment policies, benefits and financing have changed so much in the past few years, it would be accurate to say that we are in the midst of a Federal health policy revolution. This revolution is no less true of Medicare's administrative practices.

Twenty years ago Medicare was still small and it was not a managed system. It was a decentralized bill-paying program based on agreements between the government and insurance companies for them to pay medical bills of the elderly using private insurance practices.

Today, Medicare is one of the giant sequoias among government programs. Already, it is spending $120 billion a year and paying for over a billion services. Most importantly, Medicare has freed itself from the check writing mentality of its first two decades. Over the past six years, Medicare has started to become a managed program. Increasingly, it is setting its hospital and physician payment rates and inquiring into the quality of care received by its beneficiaries.

Today, managing Medicare is one of the Federal government's most complicated and difficult jobs, both for the Congress and for the Executive Branch. Medicare will rank near the top of the Federal government's growing responsibilities for at least the next half century.

Congress and the Executive Branch have responded differently to meeting the challenges of managing Medicare. Congress has

sharply expanded its own capabilities, creating the Prospective Payment Assessment Commission, the Physician Payment Review Commission, the Prescription Drug Payment Review Commission, and the Bipartisan Commission on Comprehensive Health Care. It has expanded professional staffs in the Congressional Budget Office, Congressional Research Service, Office of Technology Assessment and General Accounting Office. It has commissioned studies from the Institute of Medicine and other organizations.

In contrast, the HHS and HCFA policy and management capacities have not kept pace. The new HHS Secretary and HCFA Administrator will need to put stronger Medicare management near the top of their agenda.

The major point of my written testimony, Mr. Chairman, is that the Medicare program over the next five years faces the greatest administrative challenges since its enactment. If Medicare's management is not up to those challenges, there will be major problems and much more of the beneficiary confusion that Marilyn Moon has described, and many more of the complaints to political leaders that have already begun to appear for hospital payment changes.

The five basic challenges that Medicare is going to face will be: First and foremost, dealing with physician service volume. Karen Davis has already gone into that in detail. Second will be implementation of the catastrophic insurance legislation, particularly the new drug benefit which requires a massive increase in administrative capacity. A third management challenge will be transition to a new physician payment system. Fourth will be further reforms of DRG hospital payments to accommodate the kinds of local problems that are already appearing in the system. And finally, Medicare faces the task of beginning to build, on the respite care benefit enacted last year, the administrative foundations for long-term care insurance for the elderly.

This is a very full agenda, Mr. Chairman.

As to recommendations for what this committee might do, I have one general and one specific suggestion. The general recommendation is that the committee hold oversight hearings on these and other management issues with the new HCFA Administrator to express its concerns about the directions and importance of the new Administration's actions in these areas.

The specific suggestion is that the committee hold detailed hearings on the explosive growth in part B volume and what should be done about it. The part B volume increases, Mr. Chairman, are so extraordinary that we may be witnessing widespread abuse of the public trust. The potential responses to this problem are complex and important, and they will need careful consideration.

Thank you.

[The prepared statement of Mr. Etheredge appears in the appendix.]

Senator ROCKEFELLER. Thank you very much Lynn Etheredge.

Harris took a poll recently and found out that 89 percent of Americans felt that the U.S. health care system required fundamental change and that 61 percent said that they would favor a system like the Canadian system. I do not know how much they knew about the Canadian system but in any event, that was their response.

Which basically means that they want the government to pay most of health care costs, and they want it to be done out of taxes, and that the government should set all fees charged by hospitals and all fees charged by doctors.

This is a question to any of you, and for you to debate amongst yourselves if you wish to.

Do you think that the U.S. system needs changes that are as dramatic as that? Do you think that the Medicare program, which in some ways is close to the description given of the Canadian system, is in fact a reasonable model for a more universal system of health care?

I would also ask Dr. Lohr to comment within this context on the quality of care that might be affected by doing something of that sort. Do we have any way of comparing the quality of care now provided under the Canadian system as compared to what we are doing here in this country?

Dr. Davis.

Dr. DAVIS. I would be happy to take a crack at that. I think there is no question that there are many aspects of the Canadian system that are quite admirable. Their experience with containing costs is good. They complain about it. But relative to what we have experienced, it is quite good. Their total health spending is 8 percent of the gross national product versus 11 percent for us. Furthermore, their percentage has been flat through the 1980s, so it has not been going up; and ours has been rising as a percent of the gross national product, going up 2-1/2 percentage points over the 1980s.

Senator ROCKEFELLER. Why?

Dr. DAVIS. The basic feature of the Canadian system that I think is behind this is the fact that they do negotiate hospital budgets and physician fees on a Providence by Providence basis, and that they have the authority to make those stick.

When you asked, "Should we adopt it?" I think it is very hard to adopt any other country's system and apply it in the U.S. Their system is totally tax-financed. There is no role for private health insurance. We have $125-$150 billion private health insurance industry. It would be hard to totally displace it.

But I do think there are ways of looking at their provider payment systems and adopting certain elements of those. They have fee schedules that are negotiated, which is what I think we ought to move toward in the Medicare program.

In British Columbia, they have instituted this concept of expenditure targets. They set a total ceiling on physician expenditures and if the physicians hold spending within that, then they get their fee increases. If they are above it, they have a reduction in their fees.

So I think we should look particularly at the provider payment policies in the Canadian system, with a view to trying to adopt some of that in the U.S.

Senator ROCKEFELLER. What about the effect on quality, in fact, Dr. Lohr, on the Canadian system?

And to any of you, what is the effect on the physicians. Are they training to become doctors or is their work less motivated because of this system?

Dr. LOHR. Let me try to rephrase what I understood the two of your questions to be.

One was whether quality of care in this country might be affected by a change as fundamental as the ones you outlined [concerning moving toward a managed, or a "Canadian system"]. My answer is that change is always disruptive. Whether we would see short-term decrements to quality of care, to be superceded by longer-term improvements, might be something of an empirical question, but that would be what I would expect. As a general proposition, change is unsettling—in this case both to beneficiaries and to providers.

A second question, perhaps implicit, is what can we say about quality of care and how to measure it. We have very little base line information about how good quality of care really is in this country. We know a great deal about variations in the use of services. We surmise things about variations in the effectiveness of those services and in outcomes. But when we really look in the literature and otherwise try to pin down what do we know about quality of care, it becomes a little ephemeral. I would point to the fact that we knew very little about the levels of quality of care in this country before PPS; therefore, it is very hard to claim, or at least to demonstrate, that the phenomena you see now in the aftermath of PPS are attributable to PPS.

I also think that we have good ways of measuring quality of care; in principle, they would allow us to make some comparisons between Canada and here. In this context, however, I would like to draw your attention to the very good data systems in Canada; we are only beginning to approach these in the Medicare system and we do not have them for the non-Medicare insured populations.

Senator ROCKEFELLER. Dr. Moon.

Dr. MOON. I certainly agree with both Karen and Kathy. I would only add, in keeping to my role of talking about beneficiary issues, that when you talk to Canadians, they like their health care system. They are very satisfied with it and it meets some of the concerns that we have about the health care system here, such as simplicity and ease of dealing with the system. That, I think, is one of the things that people find very appealing about Canada.

Senator ROCKEFELLER. They get to pick their doctor?

Dr. MOON. Yes, they indeed do get to pick their own doctor. They do not have to pay bills; they do not have to worry about financing at all. They face few constraints in dealing with the health care system.

Senator ROCKEFELLER. And can go back to the same doctor?

Dr. MOON. Yes, indeed they have a lot of choice.

Senator ROCKEFELLER. And that is critical, is it not, in terms of—

Dr. MOON. I think it is critical. But I also agree with Karen, that it would be very difficult to just transport the Canadian system into the United States. There are lessons to be learned there which might work with our existing system of private insurance that serves a lot of working people very well in the United States.

We do need to look very seriously about filling in the gaps. And the Canadian system can offer some good lessons in that regard as well.

Senator ROCKEFELLER. Senator Heinz.

Senator HEINZ. On that issue, by saying that there are certain things that are transposable, are you basically talking about trying to make sure there is a continuity of care, that we do not have the kinds of—this is long-term care, this is acute care—distinctions that we now are subjected to. Is that what you are basically saying?

Dr. MOON. Definitely. I think that is important. Although the Canadians do not have a consistent long-term care system across all the provinces and in some places it is better than in others, it is a major advantage of their system.

The ability that they have to deal with costs on a global level and negotiate fees is more advantageous than trying to do so, for example, only for the Medicare population in the United States. The concern is that if you do not set fees well, physicians and other providers may discriminate against one group of patients in favor of another.

Senator HEINZ. Two questions. I do not know if I will have time to ask them both. One relates to quality. The other relates to the issue that this committee, particularly the Finance Committee, will confront in terms of controlling costs.

Let me do the cost question first. We have heard a lot of testimony today about the acceleration of the overall cost of part B. Karen Davis pointed cut the stunning fact that it will surpass part A, and it is certainly gaining rapidly. All of you indicated that there seems to be an unexplained increase in volume. Can anybody better explain it?

Yes, Dr. Young.

Dr. YOUNG. In regard to the earlier question and that one, a fundamental difference between this Nation and all others is in the volume and intensity of services. That in part has to do, I'm sure, with financial incentives. But it also has to do with deeper desires within the American public.

We have in this country, however, extraordinary practice variations and the medical literature is quite strong in pointing out the overuse of Cesarean section, of coronary bypass surgery, of hysterectomies, of prostatoyomies, and yet we persist in wanting and receiving those services. The public opinion polls, depending on how you ask the question, leaves you with very different answers. On the one hand, if you ask it as a general question, should we reduce costs and should we reduce services, people in aggregates will say, yes. In parentheses what they are saying is, yes for other people, but if I am confronted—if my family is confronted, if my loved ones are confronted—I want you, the doctor, I want you, the hospital, to do absolutely everything possible.

In the issue of bone marrow transplants, liver transplants, heart transplants, we have confronted ourselves with that repeatedly—with the desire to provide more services to more people, even when there is questions about the value of those services. Other examples include magnetic residence imagining and other technologies. This Nation leads the world many fold in the availability of those serv-

ices. Were we to attempt to reduce them, however, there would initially be, I am sure, a very strong public outcry.

When length of stay decreased dramaticly in the Medicare PPS, as you recall, there was a wide public outcry about patients discharged quicker and sicker. Yet, over time, we found out that there were not systematic adverse consequences. In the initial years, however, there was great concern about that subject. So, any attempt to reduce volume is going to be confronted with immense concerns that quality of care will diminish and in some cases it might. We do put ourselves at risk.

Senator HEINZ. Well, the one strategy that has been suggested —and one or two of you have mentioned it—is what has become known as the "effectiveness initiative." To what extent is the effective initiative as conceptualized at HCFA aimed at part B services, to physician and out-patient services, and to what extent is it aimed at part A or both?

Anyone?

Dr. YOUNG. I believe that it has an impact on both sides and I think that it is an initiative that is long overdue and one that I personally support. The caveat I have is that we have sponsored hundreds of millions of dollars of research in coronary bypass surgery, as an example, and yet we are still doing far too many of those procedures.

So I think the initiative is important. I think we should move forward to know, and to understand better, but I think we have to take that information and apply it much more vigorously than we have previously through our payment system and mechanisms.

Senator HEINZ. You can certainly respond. And anything you want to say, by the way, Dr. Lohr, Mr. Etheredge, about what we ought to do—whether the effectiveness initiative is sufficient or misguided or needs to be supplemented, I would certainly welcome.

Yes, Dr. Lohr.

Dr. LOHR. Let me make a couple of points. One is that I believe—and I am speaking personally—that the Effectiveness Initiative at HCFA ought to be understood and supported as part of a larger package that involves a variety of research efforts, including those of the outcomes effort at the National Center for Health Services Research. I do not think any of these activities should be seen as the only answer. There is a broad set of things that we can move on simultaneously.

The second point is that the Institute of Medicine has been asked by the HCFA Administrator to advise them on their Effectiveness Initiative. I would be happy to share information about what we have done so far for the agency. [See Letter Report to the HCFA Administrator in the Appendix.]

I would also support what some of the other panelists have said—namely that the issue of looking at practice guidelines, developing clinical indicators, understanding the effectiveness of services, and making that information available to providers and to patients and consumer groups will be critical in trying to optimize the provisions of both part A and part B services covered by Medicare. I might add one specific point. The Effectiveness Initiative at HCFA is certainly in a position to look at both part A and part B services.

Mr. ETHEREDGE. Mr. Heinz, three quick points in answer to your question. One is, and I think Karen already said this earlier, we do not know enough about the part B volume increase. I would underscore that that in itself is a major problem that we ought to address. This is a $40 billion program. It is growing 15 percent a year. We should have done many more studies to know exactly where those increases are coming and to find out why they are coming where they are. That is part of what I was referring to when I said I think the Executive Branch has not done what it should have to manage the program because we still do not even have a good handle on this problem, even though it has been building for ten years.

Senator HEINZ. Thank you.

Mr. ETHEREDGE. The second quick point is that, the range of variations across states, five to six to one in procedures per thousand for different procedures, and the ranges in rates of increases across states of 200, 300, 400 percent differences in rates of increases across states, are so large that it is hard to attribute these changes to changes in scientific knowledge. Many of us suspect that economics is playing a much more important role in the growth of the health system than the advance of medicine. I wish I could answer it more carefully than that.

The third, which I think is also important, it goes back to the Chairman's question about Canada is, your strategic question for this committee is, to what extent should the Federal government and its managers be getting involved in and even entangled in oversight of the practice of medicine. This has been a continuing issue for 20 years in the Medicare program.

All I can say is, I see a certain logic to the events of having to deal with the intricacies of hospital payment and intricacies of volume increases that makes me—I can only think of the metaphor of grabbing the tar baby firmly with one hand and then as it becomes more of a problem, grabbing it with a second hand to try to deal more affectively with it. And I have a feeling that the way in which we are going at the Federal level is going to get the Congress gripping the health care system with both hands and then wondering what to do with it.

That leads me to think that the Canadian system has a lot of merits.

Senator HEINZ. Thank you, Mr. Chairman.

Senator ROCKEFELLER. I would like to suggest a change in rules here. Let me just consult with my colleagues. In order that this is more freewheeling, the five minute discipline, I think, is constraining. And so, I would suggest, Senator Danforth, as you proceed that we take off the clock and that not only members of the panel but colleagues should feel free to interject views based upon Senator Danforth's line of questioning. But paying respect to his desire to pursue his line of questioning and get through with it, so that we can encourage conversation.

Senator DANFORTH. It sounded like a good idea until the last part of it.

Senator ROCKEFELLER. Senator Danforth. The clock will not be on.

Senator DANFORTH. I feel that a great bonanza has just been given to me. (Laughter)

Well, I really only have one point to make but it is a pretty big point.

Look, our population continues to get older; our technology continues to get better, more exotic, more expensive. It is possible to spend huge amounts of money keeping people alive. One thing that I do in my other life is call on some very old people in their homes. I have had people say to me such things as, "I'm growing old as hell. I think they should let me die." And we have developed these magnificent technologies for keeping people alive.

The cost of health care in this country has now reached 11.5 percent of the gross national product. It is said that despite that, Americans are not living longer, infant mortality is greater than in other parts of the world and that by the end of this century—which is only 11 years off—health care will reach 15 percent of the gross national product.

And yet when we are called to deal with it here in Congress, it is microscopic tinkering, negotiated largely through experts in the details of health care. I can remember the last time we went through this drill in the budget. I guess it was about a year and a half ago. We would be convened like on Sunday afternoons and told the latest state of negotiations in this two or three page single-spaced laundry list of fine tuning of Medicare and Medicaid laws.

I do not know—maybe I am just dumb—but about 90 percent of that tinkering I did not understand. So, my question is: Is there any handle to this, that we can put philosophical and ethical thinking into, or is the sky the limit?

I mean, is the basic rule that the number one priority in this country must be to pay for more, and more, and more, and more health care? And that everything else is secondary—education is secondary, international competitiveness is secondary, investment in industry and science and so on is secondary—because the number one priority is to spend ever larger portions of our resources in this country on the number one objective which is to keep people alive forever.

Now I do not want to sound like Governor Lamb and I do not propose to sound like Governor Lamb, but what I have heard mainly from your testimony is stuff I do not understand. But I do understand the basic question of how much and whether there is any limit and whether there should be any limit.

So what I would like to know is: Should there be any limit to what we as a Nation are willing to spend on health care? And if the answer to that is yes, then who is to determine what that limit is? And how are we to go about making that determination? You have one minute each. (Laughter)

Dr. YOUNG. Well, sir, I think you understand completely. That is the point I tried to make. For an individual patient, this Nation's ethics will not allow us to say no. The State of Oregon attempted to control its expenditures on transplants and there was a public outcry. Last week the State of New Hampshire attempted to get out of paying for a bone marrow transplant for $200,000 for a single child and there was an outcry and an uproar.

We will bring to bear thousands of dollars and many people to retrieve a child from a well. We cannot say no to an identified individual. And I believe whether you agree that it is right or wrong, that for the foreseeable future, this Nation will not be able to say no to individuals. And if we have the technologic capability to do the heart transplant, the liver transplant, we will continue to proceed to do so.

Senator BAUCUS. His question is to address what other countries do—because I know other countries set some kinds of limits. So in answering the question, please address not only our cultural response to this very fundamental question, but also the cultural response in other developed countries.

Senator DASCHLE. Mr. Chairman, in addition to that, since you have invited us all to interject here—(Laughter)

Senator ROCKEFELLER. This is the major question from everybody. (Laughter)

Senator DASCHLE. I would question Dr. Young's position. Now, we say no everyday to those who do not have catastrophic health care because they have been in a car accident. We turn poor people away in urban hospitals. We do not have health care in rural areas. We say no everyday.

Dr. YOUNG. That's the difference.

Senator DASCHLE. But we certainly say no to the day-to-day operation of health care in this country and we say no in a very calloused way in many respects as policy in this country.

Dr. YOUNG. I absolutely agree with you. The difference is in the identification of a specific individual. We will not martial those resources for hundreds of automobile deaths a day, but we will for the one child.

When the case is identifiable, when there is a doctor, a patient and a hospital, we cannot say no. We can say no by not having a hospital available in a small rural area, but that is not a single identifiable patient.

I very much agree with you. I am not inconsistent with your position.

I have used up my minute, but I will comment there are two ways other nations do this. One way is by queing. You simply create long waiting lists. The patient who could have the trick knee repaired or the cataract extracted, simply has to wait a long period of time. They may decide not to do it or their turn may eventually come up.

The other way they do it is simply not having the services available. They do not have MRI scanners across Canada and across England as we do in this country. They do not have the availability of end stage renal disease services in England or any other country to the extent we do. So we get into a vicious circle by making the services available and then we use them, and then we need of them, and then we use them.

Senator DANFORTH. I still do not think you have given me any answer at all. I know you are trying—

Dr. YOUNG. One clear answer—

Senator DANFORTH. —but I have not heard any hint of how we can get a handle on this problem other than budget resolution after budget resolution, putting on those things that jewelers put in

their eyes and working on the details of some statute that most of us cannot comprehend. I have not heard any notion as to how we, as a country, address what is a fundamentally ethical question, and that is, how much do we spend on what.

Dr. YOUNG. I think one clear answer that I implied is that, as a Nation, we wish to see that fractional amount of our gross national product continue to rise for health care. As of today, we value that, as you stated, as one of the most important commodities. And we will eschew other services that are necessary, such as the large number of uninsured. That is one clear answer and I think many people have spoken to say, let us continue to do that because we cannot say no.

The other answer is that we become—

Senator DANFORTH. I have never heard anybody say that.

Dr. YOUNG. Ask any individual patient when they are in the hospital if they should not have services.

Senator DANFORTH. Sure they do. But I mean, that is not a policy consideration as to how the national resources are spent. That is just each individual saying, "I am number one; take care of me."

Dr. YOUNG. The policy decision is to continue as we have to let the revenues and the outlays chase the costs.

Dr. DAVIS. I guess I would disagree with the fact that we have a national consensus that we want to keep spending more and more of our gross national product on health care and that we are satisfied that we are getting good value for what we are spending. I do not think that is the case and I do not think that fine tuning and these little bitty budget savers accumulation will do the job, particularly in the area of physician payment. I think you are going to have to bite the bullet and have fundamental reform of the way you pay physicians.

I think that what we have now is that physicians decide how much to charge for services. They decide what kinds of services people will get and then payers pay it. We are the only country that has gotten to fairly extensive coverage of hospital and physician services and are still letting physicians decide how much they would like to be paid. And then we are shocked that it turns out it is 18 percent more this year than it was last year, and next year it is going to be another 18 percent more than it is this year.

It is not inevitable. Other countries are not having that experience. Canada is holding health spending as a fraction of the GNP flat and they are going it without denying services to people who are uninsured because they have no uninsured. They are doing it while providing care to people in rural areas. They are doing it without rationing care for the terminally ill or rationing care significantly for anybody. How are they doing it?

First of all, they do not pay the kind of outrageous fees that we pay. If you look at what we are paying for different surgical procedures, what we are paying for radiological procedures, anesthesiology charges, we have never tried to say, "This is a reasonable fee. It will cover your costs and a reasonable return to the physician for providing that service and that is the maximum amount we are going to pay."

We have never looked into practices like physician ownership of radiological labs that was in the Wall Street Journal yesterday—that has a financial incentive of the physician to refer patients for tests because they have an ownership share in those facilities.

I think that when you ask about physician morale earlier, I think morale is better in places like Canada because they give the physician more clinical autonomy but what they give up is economic autonomy—that the government has the right to set fees, in that case in negotiating with the physicians. They set in British Columbia a total ceiling and say, "This is the maximum amount we are going to spend. If you spend more than that, we are going to cut your fees back." As soon as they put that system in place, they had no further increase in utilization.

Physicians can look at what is necessary, what is unnecessary, and live within a ceiling if you impose it. We have not tried doing that today and I think that is what we are going to have to do.

Dr. Moon. I would reiterate, as part of my answer, what Karen was saying. You have to find ways of breaking some of the financial incentives to "game" the system by providing enormous volumes of services.

If you look at ambulatory surgery which is blossoming in this country, it appears for Medicare beneficiaries, that these are largely new surgeries. We have moved some things out of the hospital, for example cataract surgery. But enormous numbers of ambulatory surgeries seem to be simply new surgeries that would not have been performed a few years ago.

Not all of this is inappropriate. Some of it is due to the fact that procedures are safer, and better, and people benefit from them. But some of this increased volume may result from the strong financial incentives to perform those procedures where reimbursements are very high.

As a country we do have to bite the bullet, but we need to think in terms of long-term solutions. One of the ways that we differ from other countries is as Don Young has talked about—our very strong notion that we ought to be able to get whatever we want, whenever we want it, and as much as we want.

Without telling any one individual no, we do have to work on educating both providers and patients that more care is not always better, and it is okay to accept lower levels of care. I think it is a change in attitude that is necessary, not rationing.

Other countries view health care differently than the United States does. Their citizens do not instantly think of rushing to the doctor if they have a cold. They do not instantly think of rushing to have six extra tests if they have a problem. A lot of that is not rationing, but the way in which peoples' attitudes are set. Changes will not happen overnight, but I do think that some of the effectiveness and appropriateness research will help if the information gets beyond the providers, to the beneficiaries and if people understand that medicine is not always a science—it is an art.

This solution will take a very long time and we are going to have some problems in the meantime. But I think that changing attitudes is the only legitimate way in which we are going to bite that bullet. But it is not a magic bullet and it will not happen overnight. And it is going to cause some pain in the process. It is not

reasonable to believe that we in the United States are ever going to be willing to say, "We are going to ration for individuals." We are not going to say, "No more care beyond this certain point."

We have come too far, I think, to go in that direction.

Senator BAUCUS. I have a question. How do you somehow set limits on fees? Like you said Ontario or British Columbia, some Canadian province, as I understand it, negotiates with the physicians in that province to set an overall target, overall limit. Then once they have reached an agreement, as I understand it, the physicians then negotiate among themselves to decide which physicians get reimbursed at what rate.

But another component we have to figure out is medical malpractice. What is the legal standard for damages and standard of liability in Canada, or Ontario, or BC?

Dr. MOON. I think you are right. We are a much more letigious Nation than Canada is.

Senator BAUCUS. Well, it is not a litigious factor, but it is a standard of liability. Can you address that component, that factor, in Canada? Because obviously if I am a doctor and I agree to a certain fee and—lo and behold—somebody sues me or I have to pay medical malpractice premiums at such an outrageous rate, it does not work for me.

Could somebody address that component, too, please?

Mr. ETHEREDGE. All I can say, Senator, is that—actually if you read the history of physician payment reforms, the first physician fee schedule dates back to 1750 B.C. in the Code of Hammurabi, 3700 years ago. It had two components—one was a physician fee schedule and the other was a schedule of malpractice awards. (Laughter)

So, the two seem to go together.

Senator BAUCUS. Are we going to follow that with an "eye for an eye"? (Laughter)

Mr. ETHEREDGE. You are looking at a sort of political balancing in what the physician community might gain as part of a package in which their fees are regulated. Many physicians would think that a more orderly way of dealing with malpractice would be a benefit to them.

Dr. DAVIS. I do think you can overestimate the impact of the malpractice. If you really look at what it is, it is a proportion of total physician expenses. You are talking about 2 percent or so. For certain specialties, like obstetrics and neurosurgery, it is much higher. I think in any physician payment system you are going to have to build in an adjustment for malpractice costs.

In terms of what to do about malpractice, more generally, I think some States are trying different approaches. Maryland has a nonbinding arbitration panel of three persons, including one physician, that first reviews any claims. That has been very effective in just targeting awards on things where there really is the 1 percent or 2 percent of physicians or cases where something really has been neglect. That is one mechanism.

Other mechanisms that are suggested are limits on awards, or limits on contingency fees.

Senator ROCKEFELLER. Let me go to Tom Daschle.

Senator DASCHLE. Thank you, Mr. Chairman.

After Senator Danforth's question I would like to come back to some of the more rudimentary questions that we have to face this year. I think it was a very refreshing discussion and one that I think we really have to face from time to time as we compare what we have to what we would like.

But, more specifically, and perhaps parochially, Dr. Young, I do not think the ERG system is working at all with regard to rural hospitals. Last year they lost a bundle. In South Dakota it was 7 percent. Most hospitals in South Dakota are going to close their doors in the next five to ten years unless something very dramatic changes.

It goes back to Dr. Bohr's comment, and I was going to preface my question by responding a little bit to her remark about quality. I think we do have quality in this country. But as she said, and I think I understood her to say, it is the allocation of quality that concerns her as well. I view allocation as a question of geographic as well as income. We have the intercities and urban problems related to allocation. We haverural allocation problems. And then we have income allocation questions regardless of where one lives.

My biggest concern right now is the allocation of health care in rural areas and what devastating problems exist as a result of the lack of adequate allocation in resources to rural hospitals, and similarly, the lack of adequate incentive for doctors to serve rural areas. For some reason—whatever the reason is—the sole community hospital protection is not working either. So you have a breakdown in policy here that is becoming a matter of crisis proportion in our State.

I would like to have you address that—and anyone else who wishes to talk about it in the moments that I have.

Dr. YOUNG. Yes, sir. I certainly understand your point and we have heard it from rural hospitals throughout the Nation. One could argue, however, without being an apologist for PPS that, in fact, what you are describing is a manifestation that PPS has worked very well. It was intended, as you recall, to reduce costs—to provide efficiencies in services both in urban and in rural areas. The budget deficit and the very low updates that I indicated during my testimony have indeed reduced Medicare expenditures. But what you are reporting is the other side of that.

At the same time, hospital costs across the Nation have been going up at 10 percent a year. That links us right back to our earlier conversation. Do we wish to contain costs or do we wish to let the costs continue to go up? There are further adjustments and many have been enacted by this committee—by the Senate and by the Congress—to help deal with the rural health problem.

However, the rural health problem goes far beyond the Medicare program. Even if we were to eliminate the difference in the standardized amounts and move to one standardized amount for Medicare, which would greatly increase relative payments to rural hospitals, many would still have problems. Admissions are down in rural areas. The demography of rural areas is changing. There are older people. Hospitals have very low occupancy.

Senator DASCHLE. But should not our DRGs and PPS take that into account? I mean, it made some assumptions. Right or wrong, it

made the assumptions. And from those assumptions come payments that simply are not working.

It appears to me that we have to come to the conclusion that those assumptions, if they were not wrong originally, are certainly wrong today and need to be reconsidered as we recalculate DRGs in the future. Would you not agree?

Dr. YOUNG. I certainly agree with you. And, in fact, in the past two years a number of those adjustments have already been made. The assumptions have been challenged. There have been policy changes—such as higher updates for rurals, a separate outlier pool for rurals. The gap is narrowing, but the gap has not narrowed nearly enough to ensure the financial survival of those hospitals.

Senator DASCHLE. So what do we do?

Dr. YOUNG. There are two broad choices. One broad choice is to say that the problem resides primarily in the Medicare program and to significantly increase payments to rural hospitals. Then you have two choices— you can reduce payments to urban hospitals or you can simply put more money into the system. One clear choice, that is for Medicare's part.

Second, you can say the problems in rural areas go far beyond Medicare, as they do, and that there is a better and alternative solution that goes beyond the Medicare trust fund for dealing with these. You can pay hospitals on a cost basis. You can create other kinds of mechanisms to help the rural hospitals survive.

I think those are clear policy choices that need to be debated and solutions need to be found to ensure access in rural areas.

Senator DASCHLE. Dr. Lohr.

Dr. LOHR. I might add one other partial solution. That is to look at areawide networks of hospitals. There is a reasonably good example in Eastern Washington and Idaho that might serve as a model. There are similar models in Colorado and in Montana—that is, in the Pacific Northwest and the Western Mountain States. That might be a step towards rationalizing the provision of care in rural areas. It might allow some hospitals to stay open and survive on their own and, in fact, have others close or reduce the types of services that they provide so that they are not faced with such high costs of acquiring technology that would be expected of them if you applied an urban standard, which is not a feasible option I do not think.

Senator DASCHLE. But is that not what we were doing with sole community hospitals?

Dr. LOHR. I would like to let Don—

Senator DASCHLE. That is the concept behind sole community hospitals generally.

Dr. YOUNG. Sole community hospitals have some level of protection by relating their payments back to their historical costs, but that is only a very partial solution and only for some hospitals.

Senator DASCHLE. Well, the point is that sole community hospital protection has not worked either, for whatever reason.

Dr. YOUNG. That is correct. That is absolutely correct.

Senator DASCHLE. Which is my point.

Dr. YOUNG. On the other hand, I would tag onto Kathy's comments and say, we may need to entirely step back from our historical concepts. It may be that a rural area does not need what we

have historically called a hospital. What they need are good emergency services. They need triage; they need transportation to get certain people into centers of excellence where they can get the high quality care they need. By paying for a building that is called a hospital under a set of rules, we require them to have a library. And we require them to have all sorts of things that they do not need.

We need to step back and say, do we really want to call this a hospital or rather, change the whole idea of what we call this and say we will pay you based on the services that this community needs. You should not be doing elective surgery here. You should not be doing things that they are doing in the big city, but patients can be transported for those services. And this might beef up what they really need in the rural area in a way that is far more efficient than the current mechanism of a hospital, requiring certain rules when there are only four people in it.

Senator DASCHLE. Thank you.

Senator ROCKEFELLER. That is provocative to Tom Daschle and Jay Rockefeller because that gets into the whole concept of rural health. In order to follow up, where is what you have suggested being practiced and how do the beneficiaries of that service react to it in rural areas?

Dr. YOUNG. There was some legislation a year or so ago that was funded for some demonstrations along that line. One site is in Montana and we will have much more information—HCFA is funding this—on how this kind of activity works out. But, it is entirely possible—while it will not solve all problems everywhere—it will be in large measure what farmers and others are looking for. I do not know the answer to that. But I think it is likely, at least in some areas, that it will be an improvement.

Senator DASCHLE. Mr. Chairman, I have to chair a meeting at 11:30 and I will have to excuse myself. But I commend you, as well, for this hearing. I think it has been an excellent morning and I appreciate the testimony of all of our witnesses very much.

Senator ROCKEFELLER. Thank you, Senator Daschle.

Dr. DAVIS. If I could add a word in response to Senator Daschle's comment.

Senator ROCKEFELLER. Please.

Dr. DAVIS. I think the problem goes beyond just hospitals. Dr. Young's remarks are assuming there is a good primary care network out there and that there are enough physicians to provide these services. I think in many of these communities we also have a problem with payment to physicians. And as we look at changing the way we pay physicians, we are going to have to bring rural physician fees up to a level that is comparable with what physicians in urban areas make. Because I think a lot of them are not finding it economically attractive to practice.

For example, if you think about paying $50 for a service today in an urban area, a rural area might be getting $20 or $30. You could justify some difference just based on differences in the costs that they have to pay their nurses or the rent. But other than adjusting for that cost of purchased input, Medicare should be paying the same fee in all areas. That would help make primary care practice more attractive in many of these rural areas.

So I think as we look at the issue of physician payment reform, we need to look at how it will affect rural areas.

Senator ROCKEFELLER. But you see, that is the catch because this is the year that we are going to be looking at how the doctors are paid. That is going to be a very contentious issue. In fact, I would ask your comment on that. In my State, five hospitals have closed in the last 18 months and the average rural hospital lost $750,000. So, I guess, then logically you could say, Dr. Young, they are not working and, therefore, we should have emergency services or other ways for doctors to provide those services. But hospitals attract doctors.

The county where my wife and I have a farm in West Virginia is a very large county. It is a very rural county. It is one of the largest counties east of the Mississippi and it has less than 7,000 people in it. We were thrilled when a young couple came from West Virginia University's Medical School—two Dr. Jones'. A married couple—it was a real bonanza. There is no hospital in the northern part of that county and it is big enough so that if there is no hospital in the northern part of that county, that becomes a real factor.

They stayed as long as they could but people were unable to pay them. There was a will to stay. They came specifically because the place was rural, because there are caves and historical logging trains—It is a marvelous place to live. It is the quietest place east of the Mississippi in terms of noise, which is why we have a National Radio Observatory there. It is idyllic. It is the reason that I chose to purchase a farm there. It is a perfect setting for rural living. But they had to leave. And that is the bottom line.

There was not a hospital there and people were not paying their costs. So how does this alternative system—and there is an experiment going on in Montana and I will be glad to hear about that—but can you tell me more about what is being done in other countries and whether it is working. And, Dr. Moon, how are beneficiaries reacting to it?

Right now, we have no doctor to go to if our nine-year-old gets a 104 degree temperature.

Dr. YOUNG. We do have, Mr. Chairman, a bit of a paradox here. First, as you recall from a few moments ago, I was the only one who was bold enough to suggest that perhaps this Nation wants its expenses to continue to go up. And one alternative is that we can fund and support services that now are financially at risk.

As I mentioned to you before the hearing started, I have a home in West Virginia in Tucker County. One of the hospitals that closed in the past year was, in fact, Tucker County General in Parson. At that point, I also was aware if I have an emergency while I am in West Virginia, I am going to have to go further on to Elkins to get care. So I also love the setting of West Virginia and that was a change that affected me.

Senator ROCKEFELLER. And Elkins was formerly two separate hospitals merged into one.

Dr. YOUNG. And now there is one.

Senator ROCKEFELLER. And that one is now struggling.

Dr. YOUNG. Yes, that is correct.

So one alternative clearly, as I said earlier, our Nation would like to control very expensive things, would like to control doctor's

fees, but would like to assure we have access. That is why I made that point a while ago.

On the other point, however, I think a great deal can yet be learned. I do not believe there are models in other nations that look like the way we have structured our health care system. Historically, we had a doctor and we had a hospital. That has changed now because of technological changes. The continuum of care for when a patient is acutely ill, and when he or she needs transitional care, and when he or she needs nursing care is indeed a continuum. It does not end at one point and start at another.

I think it is well worth pursuing these alternative mechanisms and finding out if they meet the value systems of people in these areas, and I sense in many cases they will.

Senator ROCKEFELLER. Do you think it is inevitable that rural hospitals are going to continue to decline, more or less, regardless of what we do here in the Congress with respect to either the update closing of the past year or the Bentsen-Dole bill of this year, if it were to pass?

Dr. YOUNG. Some—

Senator ROCKEFELLER. The Bentsen-Dole bill is new money, right? It does not take from urban hospitals to help rural hospitals?

Dr. YOUNG. That is correct.

Senator ROCKEFELLER. It will cost some money.

Dr. YOUNG. I think the answer is, some rural hospitals will continue. Where there is another hospital relatively close, mileage, I think that the community will be less likely to support it.

Other parts of our Nation, such as Kansas, have for years supported their rural hospitals through a general tax because they believe it is important enough. There we are not seeing the closures nearly at the rate we are seeing them in some other states.

Senator ROCKEFELLER. Tax on what?

Dr. YOUNG. Local taxes paid by a citizen's property.

Senator ROCKEFELLER. You mean county?

Dr. YOUNG. Yes. County, property—forms of taxes.

Senator ROCKEFELLER. Interesting. Sort of a levy.

Dr. YOUNG. A levy, exactly.

So I think we will see different patterns and different value systems. But clearly, yes.

And to some extent those closures are good. The closures are good because hospitals that do things infrequently do them very poorly. If a hospital is doing elective surgery once every two or three weeks to remove a gall bladder, the chances are that it is not doing that nearly as well. We, and others, have shown very clearly that mortality increases as due per-case costs when doctors and hospitals do procedures with decreasing frequency. I think we will see more and more concentration of procedures in hospitals, both to save costs but more importantly to improve the quality of the outcome. And people will have to transport themselves more, even in large cities.

Senator ROCKEFELLER. That is a provocative thought. But that almost dooms rural hospitals or at least certain aspects of them.

In other words, if you practice infrequently then, Dr. Lohr, the quality of the service that you provide is declining and therefore, Dr. Moon, the beneficiary is receiving a poorer quality service.

Is there argument to Dr. Young?

Dr. LOHR. I would pick up on the point you made concerning of what we, sort of in shorthand, say is the volume outcome relationship. I am inclined to think the evidence is building up, that doing something more frequently is likely to provide you with lower per case costs and, at least even, if not improving outcome. So I think I would subscribe to that.

Senator ROCKEFELLER. No, I missed your point there. It sounded to me like you were disagreeing with what he was saying.

Dr. LOHR. No. No, I was not disagreeing. I was agreeing that I was putting it into positive.

Senator ROCKEFELLER. He was referring to a surgical service, I think. But let us say the service of a rural hospital practice.

Dr. LOHR. I would be inclined to say that at some point if certain kinds of services—they could be monitoring for acute myocardial infarction patients; they could be even fairly common surgical services and procedures—There will be a point, I would submit, below which quality of care would be likely to suffer and certainly the per case cost would go up. So in that sense, I am agreeing that there is a relationship between volume and higher expected better outcomes.

Senator ROCKEFELLER. But did not one of you say in your opening statement that although there was a decline after 1985, the volume factor began to come up again? Was that you, Dr. Young?

Dr. YOUNG. Yes. The admission rates to all hospitals are increasing again. But admission rates are much higher in urban areas than they are in rural. The volume decline has been much more in rural areas than in urban areas.

Senator ROCKEFELLER. So post-1985, a real decrease in rural areas continues?

Dr. YOUNG. I do not have up-to-date figures. The volume continues to be lower in rural areas. But where it is exactly at the moment, I cannot give you. But there is a relative decrease in rural areas compared with urban, but both are having higher volumes now than they were three years ago.

Dr. LOHR. If I could come back to—

Dr. DAVIS. I do want to dissent just a little bit from this general stream of thought that you get the best quality care where there is a large volume of care and, therefore, we do not need rural hospitals. I think there is no question that complicated things should be referred to a regional tertiary care center. But to deny people easy access to—whether it is primary care of hospital care for—basic things and you have to go 50 miles, 100 miles, no care in that situation can be fatal.

So I think we have to maintain a rural hospital network that has, in every region accessible to people, a preservation of access to hospital care. So it may be higher quality care for complicated things if you go into a large teaching hospital center where they do a large volume of things, but that does not justify not having ready enough access to basic care, close enough for people that they can use it.

Dr. YOUNG. I certainly did not say that we need not to have rural hospitals and that all care needs to be referred.

But the evidence on volume is clear. Now whether a prostatectomy is a simple and a straightforward procedure—it is a routine procedure of medicine—the relationship I described holds for that as well. But that does not mean that you have to go to the big city hundreds of miles away.

Dr. LOHR. Could I pick up on one point that we left awhile ago, that I think Mr. Danforth had raised, and that concerns whether or not we are reaching a limit. At some point probably we will reach a limit in terms of what this Nation is prepared to spend on health care.

But I would submit, and I think I may agree here with Don Young, that we have not reached it yet. And the real issue, it seems to me, is the allocation of the health care resources within the health sector. I would leave for another day cross-sectoral shifts between, say, education and housing on the one hand and health on the other.

There does seem to be mounting evidence that we might be able to show as much as 20 or 30 percent of certain kinds of services provided in this country are unnecessary and inappropriate. We do not know what 20 or 30 percent yet. But as I say, the evidence is beginning to mount. If, in fact, we could begin to identify better ways of understanding when certain services are appropriate and when they are not, and make that information available to providers, we might go a great way toward saving resources that could then be put to the care of, let us say, the nonelderly, to the uninsured or, in fact, to providing the services that are not now covered by Medicare but clearly, in my view, need to be—such as expanded home health care benefits.

I would come back, in other words, to the clinical indicators of appropriateness, effectiveness, kinds of work that over the next decade ought to provide providers with a great deal of more information than they already have. And I would say that is necessary in reiterating what Karen Davis said. You would like to be able to give your physicians clinical autonomy to do the best they can for the individual patient sitting in front of them and across the desk, and leave for a broader society decisions, if you will, the fiscal autonomy.

You can make a distinction there. I think she has made a useful one. But there is a good deal of basic research that needs to be done to help pin down those appropriateness, effectiveness issues and make that information available to providers and physicians.

Senator ROCKEFELLER. Mr. Etheredge wants to say something and I will come right to him.

But, when you say 20 to 30 percent may be inappropriate, does that mean, in your judgment and also, Dr. Moon, in yours, that beneficiaries are asking for care which they may, in fact, not need?

Dr. LOHR. I would say, in some sense, all of the above. Certainly patients, and just the elderly, ask for—some say demand—care that they may not need. That may fall into the category of, you know, seeking emergency room care for the common cold. I mean, there is that dimension to it.

Certainly the entire question of physician uncertainty and the way physicians have been trained to do all that they can. And when you give them the armamentarium they presently have for providing services, and not necessarily clear indications of when diagnostic tests or other sorts of procedures may be appropriate and when they can be foregone, when can you substitute one kind of test for another test, those are all issues that still need a great deal of clarification for providers.

So I would not lay it all on the patient and the beneficiary. I would not lay it all on the providers for trying to do more and more in some kind of uncontrolled frenzy of providing services. Certainly we see newer technologies that look as if they can provide a marginal benefit and we do not necessarily do a good job of substituting newer technologies for older ones. We do both.

As to the particular, sort of where the evidence comes, it seems clear that a lot of the work that has been done and published by researchers at the Rand Corporation and elsewhere show that when physicians set standards, if you will, or guidelines, or develop indicators for what is appropriate use of, let us say, credit and arterectomy, coronary angeography and so forth, and then they go out and look and see whether physicians actually provided services in correspondence with those guidelines, you see these sort of figures of 10, 20, whatever, percent of services that seemed not to have been appropriate according to guidelines that physicians themselves establish.

I am simply arguing that we need more work in that arena with that kind of information provided to physicians. And one side benefit of that might well be to help clarify the malpractice situation. I would come back to reiterating that malpractice reform, I think, is a necessary, somewhat independent, issue. But it would seem that malpractice problems do impact on issues relating to quality assurance insofar as there are not good guidelines yet for doing satisfactory peer review. Physicians become very uneasy thinking that what they may be doing in the quality assurance arena may lead to rampant malpractice suits being brought.

That is an area, as I say, that I think needs considerable attention all on its own.

Dr. MOON. I would just like to briefly add that we have to be very careful about blaming the patient when the professions that are dealing with these services and giving advice to patients about whether they need the care have not come to agreement on whether it is necessary. It is easy sometimes to talk about patient induced demand and get excited about that as a way of cutting back on health care costs. But it is very difficult to ask patients to be better clinicians than physicians are at this point.

The information first has to be developed, as Kathy has talked about. It has to be provided carefully to physicians and hopefully in reasonable ways passed on to beneficiaries. But I do not think you hold beneficiaries responsible first. I think you work with the physician community first.

Patients have a strong stake in maintaining access to services where they live. I know that some people in rural areas would rather stay in their local community hospital even if they know they can get higher tech, fancier care, in urban centers. They trust

their physicians; they trust the relationships they have there. They like the proximity to family.

Since we know that a lot of medical care is art and success depends on attitudes of patients and other intangible factors, we should not discount individuals' preferences when we think about the quality dimensions. I would not disagree that there are quality concerns in rural areas and that sometimes you are going to want to step in and say this is just not good quality care. But I think you have to be careful in maintaining some patient choice.

Senator ROCKEFELLER. Mr. Etheredge, I promise I am still coming to you.

But just to follow that up, I find myself in agreement with you Dr. Moon because, for example, a senior citizen or a person in a rural area who is isolated who feels that he or she has a health problem, does there not have to be room in this sort of tremendous drive for efficiency where outcomes are precise and where everything is meant to be balanced, for simply the person who is worried about the condition of their health. He or she may have no reason to be worried, but needs to be reassured and that sort of psychological dimension of reassurance is a legitimate factor in our population?

That is not something to be scorned although it may not show up on a chart as being a needed service. It is a dimension of human nature that cannot be changed.

Dr. MOON. I think that is right and it may be important to keep in mind that when we decry all the emphasis on high-tech care, we sometimes make high-tech a self-fulfilling prophecy if we denigrate those important intangibles.

Senator ROCKEFELLER. Mr. Etheredge, at length.

Mr. ETHEREDGE. Well, thank you.

I just have a few observations. As I was listening to the exchange on rural hospitals and which one should stay open and which should close, and how to be fair. I could not help but think of how blunt an instrument the DRG system, even at best, is for dealing with all the kinds of complexities that we were even surfacing in our short discussion this morning.

I think unfortunately the direction we are going in health policy is to increasingly get the Federal government into trying to resolve these issues for Montana, and West Virginia, and Pennsylvania, and other States, as to which hospitals have merits for different rates of payment under the DRG system. I wonder if we could not be thinking about, if we cannot go to a Canadian system right off, if we could not be thinking about steps in that direction which in a management sense allow for more of these kinds of adjustments.

One thing that was done during the cost of living counts from a period of 1971 to 1974 was to ask States to establish review commissions where the hospitals which felt they had a particular case for more money compared to other hospitals could come and those commissions were allowed to allocate up to, I believe, about 1 percent total increase in spending for the State to those circumstances that had the most merit and where the general Federal rules were not accommodating those changes.

So that would be one kind of approach that we could take. It would also move us more toward a State-based budget review

system for hospitals. And if that is the direction that we are ultimately going to be going, more toward a Canadian system, we could start to get there and build that capacity by making that kind of adjustment in the DRG system this year.

Senator ROCKEFELLER. Dr. Davis, you have to leave in a few minutes, as I understand it, to make a train and I just wondered if you had any further thoughts you wanted to share with us.

Dr. DAVIS. No. I would just like to commend you for taking on this subcommittee and the task of dealing with these problems in Medicare. And I am sure we would be happy to be of any assistance we can be at any point in the future.

Senator ROCKEFELLER. Before you go, and before Dr. Lohr, another problem. You know, we have certain professional health care providers that are not reimbursed under Medicare. In OBRA 1987, psychologists, for the first time, were given the right to be reimbursed, but only in certain settings—community mental health centers and rural health clinics.

For example, you hear very little about nurse practitioners and yet there is a lot they can do. You hear relatively little about physicians' assistants, and yet there is a lot they can do. Is there in this rural dilemma a possibility—in fact, I think we have set a limit of some sort, have we not on how much they can participate in Medicare? Am I right on that?

Dr. YOUNG. Yes. Correct. You are correct.

Senator ROCKEFELLER. Do we overdo that? I mean, in setting limits then we are also setting limits on the vision or the ambitions of those who are in their teenage years or in their high school years at either a medical career or physicians' assistants or nurse practitioner careers. I mean, are there areas that we are underusing, or perhaps discouraging, by the limits that we set—certain types of services, certain types of settings?

Is my question clear or not?

Dr. DAVIS. I think nurse practitioners and physician assistants can be an important component of the care system, particularly in rural, underserved areas. We do have provisions for payment of rural health clinics that were instituted in 1977. But I think that has never quite lived up to its promise and that we need to look at ways of trying to encourage those kinds of providers to fill some of the gaps in care in these areas.

Senator ROCKEFELLER. In West Virginia we used to get 40 National Health Service Corps doctors a year. We now get two. What has happened?

Dr. DAVIS. I am very concerned about that. In 1981 the Reagan Administration cut funding for the National Health Service Scholarship Program, which provided scholarships to students in medical school, nursing school, other health professional schools. For every year of scholarship they were obligated to one year of service in the National Health Service Corps.

Well, with medical training taking four years of medical school, three years of residency, seven years later, in 1988, 1989 we are beginning to see the effect of cutting off those scholarships. So the size of the Corps is reducing rapidly and by 1991 it will be virtually gone. That is going to be a major problem for these primary care

centers that have relied heavily upon the Corps for staffing. I think it is something that is going to need to be looked into.

Mr. ETHEREDGE. Mr. Rockefeller.

Senator ROCKEFELLER. Yes.

Mr. Etheredge. With the physician payment reforms that are going to be considered by this committee later this year, I think one of the major issues that you will want to look at is the payment rates for rural physicians. The amount of money that could be leveraged through Medicare to $40 billion of payments to address those issues is far more than was ever possible through the Health Service Corps.

Senator ROCKEFELLER. Dr. Lohr.

Dr. LOHR. Not to add to the complexity of these issues, but I want to reiterate the need for emphasis on thinking about getting physicians and maintaining them in rural areas. Things like the National Health Service Corps are important to sort of think about rejuvenating, I would say.

But I think perhaps a larger manpower issue is really the nursing shortage issue. And certainly that is a payment phenomenon. It may be a payment indirectly through hospitals. But I think the nursing shortage is becoming catastrophic and its impact on what hospitals can and cannot do in both rural and urban areas is just reaching crisis proportions and certainly could.

Despite an interest in the rural issue—and I would say my husband and I own property in Clark County, and neighboring to West Virginia, and we get care from Winchester.

I think we must not lose sight of the equally significant problems faced by intercity residents, particularly in our largest cities. I would say that they may well, particularly the lower income elderly and those of minority background—hispanic, black, so forth—face problems of access, financial and physical, that I would contend or at least as an imperical question is at least as bad as the problems faced by rural residents.

I think we cannot lose sight of the fact that in some ways intercity hospitals, big county hospitals, municipal hospitals, and so forth, are going to need some specific attention in their own right.

Senator ROCKEFELLER. Dr. Moon.

Dr. MOON. I would just like to say that there is an additional troubling dilemma here as well when we think about physician payment reform. If we try to raise payments to physicians in rural areas, to those who serve low income patients in inner cities and so forth, the dilemma is that that will also raise co-payments for beneficiaries who live in those areas, who may also have low incomes. So when you are trying to add additional access and encourage physicians in underserved areas, you also will increase some burdens on patients.

We don't know yet, for example, what the full distributional impact on beneficiaries would be from the physician relative value scale proposal that is being proposed to change physician reimbursement.

Senator ROCKEFELLER. Let me follow with a question to you and then I will come back to you, Dr. Young.

Do you think that the Medicare program should pay for preventive services?

Dr. MOON. The Medicare program should pay for preventive services that do a good job. I think we have to be very careful before we jump on the bandwagon and pay for screening, for example, where such care may not be indicated and may not improve the health of individuals. We need to look carefully at what preventive services are effective. I think mammography is a good example where there is strong evidence that this test will be beneficial over time.

In the case of some other services, and perhaps Dr. Young could speak to this, like glaucoma screening, we are not sure about effectiveness. And if we are talking about scarce dollars, we have to look carefully before we simply make a blanket endorsement of covering preventive services.

Prevention is a good idea. It certainly is not always going to be cost effective. The question is: Is it effective in terms of helping people's health care?

Senator ROCKEFELLER. Dr. Young.

Dr. YOUNG. I certainly agree with that assessment. Having been in the Medicare program before I took my current position and before that in a voluntary health agency, I have looked at the preventive services.

The problem indeed resides in the proof that this really is effective and in secondly controlling the volume of the use of the service. The potential for abuse of some kinds of preventive things—where people go to a spa for a week or two—there is immense potential for abuse in the use of those kinds of things.

Senator ROCKEFELLER. Dr. Moon, did you raise the question of simplicity?

Dr. MOON. Yes.

Senator ROCKEFELLER. Yes. That, I think, is troublesome. Because, you know, we come each year with a new wrinkle or as Senator Danforth indicated, sort of a microscopic approach and legislatures feel a compulsion to be able to show some new benefit. In the last eight years this has all begun to catch up with us and the cost now overwhelms us. And yet we still press ahead.

We make changes and then seniors find out about them years later or they are confused. What do we do? What are some of the things that we could do to try to make Medicare more understood?

It is fascinating the articles that are written about it. You just cannot explain these things briefly. I know it must be difficult for patients and for Medicare beneficiaries.

How do either we, or how do you, approach that?

Dr. MOON. I think that is a very difficult question. In an effort to provide new benefits, improved benefits, but not open the doors on increased costs, we have set up many artificial barriers that beneficiaries just simply do not understand. You are quite right.

When I try to explain to my family and friends how Medicare works, I always forget at least two or three different dimensions of the system. And I know that they have only picked up about half of what I have said anyway.

We need to focus on spending some resources on making sure that people are very well informed, not only the beneficiaries but also the providers. There are a lot of providers who do not under-

stand Medicare either. But that is only a partial step. Over the long run, we ought to try to add simplicity throughout Medicare.

For example, the new catastrophic drug benefit may make use of smart cards so that the patient may not have to deal with keeping records. If it turns out that this is a feasible approach, we ought to think about similar approaches for payment of physicians as well.

We ought to think about ways of streamlining payment mechanisms, even if we do not change what beneficiaries have to pay. At the very least, we ought to be able to design forms that tell beneficiaries what Medicare covers that do not lead people to think they have to send more money in. These forms should help people understand why their charges have not been paid or why they have been disallowed by Medicare. We do not do even these simple things well at the present time.

Senator ROCKEFELLER. Mr. Etheredge.

Mr. ETHEREDGE. Senator, I think in what Marilyn suggested is the germ of an idea that we may be able to give you something today that would help solve some of these problems. That is, to get the beneficiary out of having to submit physicians' bills.

My own experience with my grandmother and my parents is that that is, by far, the most complicated and worrisome and frustrating process I have had to go through in dealing with the medical care system. I do not see any reason why we continue to have bills submitted to the patient and then have the patient have to try and go through all this complexity of dealing with Medicare rules that they do not understand, dealing with questions of whether something was medically necessary or not, when they are in no position to answer them.

It seems to me that a very simple and a very positive change in the Medicare program would simply be to require that all physicians submit their bills directly to the Medicare program and Medicare and the physician can work out what is medically necessary and what is not, and what is allowed and what is disallowed. After that process is finished, the physician can then bill the patient for what the patient is legally liable for.

I think that would get rid of much of the complaints that we find in the system about elderly people trying to figure out forms, submitting bills and having to deal with the increasing number of disallowances, and partial allowances that come from the fee freezes, and the max, and the participating physician rules, and the things that even us health experts have a hard time understanding.

Dr. LOHR. I would like to subscribe to what Lynn has said in the strongest possible terms. I think trying to relieve the burden on the elderly on filing their own health insurance claims would go a long way towards relieving their anxieties. It also would be just simply less of a physical burden on these because if you have to go to the library to Xerox your forms so you have a record that you sent it in six months ago and so forth, that is a considerable burden on people in their eighties and nineties even who may not have access to good transportation and so forth, and so forth.

I think Lynn has hit a good solid nail on a good solid head. I might say that a secondary suggestion might be to try to see if there is as much dissimilarity across the FIs and the carriers in what they allow and what they do not allow.

My parents have recently moved from California to here. They are getting very different sort of okays from the FIs and the carriers about the bills they have. As it happened, they lived near to Los Angeles in California but were covered by the northern California Blue Cross/Blue Shield as their carrier, I think. And they knew that what they were being allowed in the way of reimbursement was different when it was judged by the northern California carrier than it would have been if they had been covered by the southern California one.

So I would say that trying to understand and rationalize and systematize and make consistent the decisions that are made by FIs and carriers on behalf of Medicare claims and beneficiaries would be a good step in the right direction.

Senator ROCKEFELLER. I have two more questions then I promise I will let you go.

We are going to have to address long-term health care and that is monumental money. The Pepper-Simon bill did not include nursing home coverage. The Mitchell bill applied only to Medicare recipients and balanced or public and private sector initiative. Obviously, that bill is a framework for discussion.

I mentioned at the beginning that with the catastrophic bill there have been a lot of questions. Congressmen, perhaps, may be more nervous about making aggressive steps than they might have been last year and yet long-term health care is overwhelmingly the number one identified need for our seniors. Medicaid has a bias toward nursing homes.

If Medicaid—and the States would have to be a part of this obviously—were to expand coverage to the home or to community-based long-term health care, in other words not maintain the nursing home bias, would that in your judgment be helpful?

Dr. MOON. That would be an important first step, if you have to do it in increments. But I think there are some other things about the Medicaid program that prevent an easy solution even in the interim because there is great variation across States in terms of the kinds of services provided and the levels of reimbursement. Some of those would also need to be dealt with as well.

The eligibility rules for individuals being covered by Medicaid vary enormously by State and in some States it is difficult to become eligibile even for nursing home care, for example. One of the advantages, potentially, of looking at home care through Medicaid is that we do need more experience in developing good home and community-based services. Your suggested approach could help speed that along.

So I guess I am not sure that this is where I would start, but it is a reasonable place to start. But once you say, we are going to rely on Medicaid for some time for long-term care, a lot of the other problems with Medicaid will surface.

Senator ROCKEFELLER. Okay.

Mr. ETHEREDGE. Senator, there are a number of States which have been leaders in expanding their Medicaid programs and their State-sourced funding programs to deal with long-term care. Illinois, for example, has made home and community-based care for the elderly an entitlement for senior citizens in the State. Texas has a very large program. New York and Maine have good pro-

grams. Oregon has gone very far toward home and community-based care. So there are outstanding models of how one can use Medicaid to provide senior citizens with home and community-based care.

It is very important to expand on those efforts because they build the infrastructure that is going to be needed whether the next stage of long-term care is a Medicaid expansion or a Medicare expansion. The key management issue for the Federal government is whether and how to get involved in the health and social services network at the local level. If we take an approach of trying to expand home and community-based care through Medicare, through a Federal approach, we build a Federal system that has to deal at every local level with those complicated networks.

Medicaid already has $25 billion of long-term care spending and a number of States have started home and community-based care systems. What does not make sense in management terms would be to build a $25 billion Medicaid long-term care program and then put a $25 billion Medicare long-term care program on top of it, each of them dealing with the same providers for the same beneficiaries but with different eligibility, different provider selection, different payment rates, different quality assurance and different managed care.

So one of the key policy issues that needs to be addressed over the next few years is: How do we go about building the management systems between Federal and State governments that are going to meet the needs of the elderly for long-term care.

Senator ROCKEFELLER. Let me ask one final question.

One of you—and I forget who it was, actually, no, I did not forget who it was. It was Dr. Davis and she is gone. (Laughter)

Dr. Davis said something interesting at the beginning. She said that in the Canadian system physicians take the managed fee with good grace in return for clinical autonomy. I found that interesting with respect to the Harvard study that we are going to be looking at this year. That is, how does one pick among doctors? I mean, it is incredibly complicated.

We do not have enough primary care physicians, OB/GYNs, or pediatricians.

People are opting out. They are choosing to go into those professions which have higher technical ability which pay more. So then you look at rural and urban, but then you find West Virginia's payment rates are lower in comparison to Nevada. Both of them are rural, but the payment rates are totally different.

It is reasonable to assume that doctors have to be motivated not only by their oath, and by their sense of service, and the sense of satisfaction they receive, but also by the compensation that they receive. So that statement by Dr. Davis was very interesting to me. She was implying a trade-off. I wonder whether the rest of you would agree with you.

I also am not sure what clinical autonomy means.

Dr. YOUNG. I would certainly agree with it. I was in practice for a number of years before I lost control of myself and ended up in Washington. (Laughter)

Doctors are very interested in having the control of their patient. I think part of the autonomy issue she was talking about was, they

do not like having to call a PRO and talk to a nurse on the PRO's staff to get approval to treat the cataract. They do not like second surgical opinions where other doctors are asked to judge their judgments and their decisions. I think they would be willing to trade off, as they have in Canada, not having to go through those kinds of hoops and to make the decisions themselves without having them second guessed, and would accept lower payment in order to do that. I think that is the point she was getting at.

Dr. MOON. There is a certain irony that in the United States we micro-manage a lot of health care decisions to a greater degree than many of the European countries and Canada, while they have much more control over the financial side. I think that Don was also talking about these tradeoffs.

There's no doubt that the process of change will be painful, though, because a fee schedule will increase payment levels for some and decrease the payment levels for others. I think that is going to be a debate that is not going to be linked at this point to more autonomy. In that sense, it is going to be a very tough issue, even though I think everyone on this panel agrees that physician reimbursement ought to be looked at very closely.

Senator ROCKEFELLER. Yes.

Mr. ETHEREDGE. Senator, this is not my usual sermon—standing up for the physicians. But I think it is undoubtedly true that the American physicians today, compared to the physicians of the rest of the Western world, are the most litigated against, the most second guessed and the most administratively burdened. I have just written an article documenting those facts with Philip Lee, who is Chairman of the Physician Payment Review Commission, which I will be glad to share with the Commission.[The article by Mr. Etheredge appears in the appendix]

I am sure you are aware of the so-called managed care revolution of HMOs, PPOs, second opinions and hundreds of utilization review firms, all using different standards or criteria, if they are using any standards or criteria at all. It is becoming quite unpleasant for physicians and they respond very badly to the second guessing of their clinical freedom.

So you are absolutely onto a right track. There are some important trade-offs that could be made, in the interests of broader agreements, between fee schedules and on quality review. Having to deal with just one quality review system, for example, one explicit set of standards, would be viewed by many physicians as a great step forward. I hope that the kinds of studies that are underway now might lead us in that direction.

There is a great deal that can be developed in this area. Physicians would be willing to sacrifice some income, perhaps, in order to have the clinical freedom to practice medicine the way they want to.

Senator ROCKEFELLER. I thought of one more.

When the Congressional pay raise failed, the judges did not get money, but I think most importantly there are, I think maybe, 2,000 to 3,000 to 4,000 senior civil servants that did not get a pay raise. The context of my question is, what do you think about those who think about health and help to determine policy in the subsecretary level, how good is the quality of that thinking?

Dr. Fletcher is the head of NASA. He came before the Commerce Committee—the day after the Congressional pay raise failed—and he said, there are a lot of people in NASA who have hung on for the last three years, people who are at the top of their salary levels and are senior, and are crucial to the program. Who have hung on because of the Challenger tragedy and felt it almost a matter of patriotic and Agency duty to stay on. But with this vote, they will go.

The National Science Foundation, The National Institute of Health, et cetera, we are hearing a great deal about that. Compensation is a fact of comfort and pride and, you know, legitimate reward in human nature.

What is the quality of thinking on health problems, Medicare problems, that comes out of the Federal bureaucracy?

Dr. YOUNG. Sir, I am not an unbiased observer.

Senator ROCKEFELLER. I know that.

Dr. YOUNG. I did work in the Health Care Financing Administration before I went to the Prospective Payment Assessment Commission.

I think that the level of the dollars and the salary was certainly something people had their eye on and in some cases may have already spent, and it is important. But I think another factor is far more important than that factor. I think that the quality of the mid to senior level people is decreasing in government and that its decrease is much due to the widespread perception that the government is our problem, that these bureaucrats are our problem.

Government service and public service, which has been highly regarded at some times and still is in other nations, is not nearly as highly regarded in the U.S. now. There have been freezes on employment so that the opportunity for career growth is less. You have to submit financial statements that are subject to public scrutiny. You have to be very careful if you travel that you do so by a set of rules. The same rules that we have heard about hospitals and doctors complaining about we hear about Federal employees complaining about.

I think it is the perception that public service is not a worthy and just profession that is more responsible than it is for dollars for young people not coming in and for people who are in mid-career deciding to go somewhere else where I can get the rewards, not dollar rewards but other kinds of rewards. That is the fundamental factor.

Mr. ETHEREDGE. Senator, please, let me distinguish between what I think of the policy thinkers and managers if I can for a moment. Although there are obviously a lot of overlaps.

I think what draws people to Washington is a chance to help shape public policy. In my perception, the biggest shift we have seen in the last few years is that Congress has established PROPAC and FIS-PERC and Prescription Payment Review Commission and built CBO and stuff. There has been a tremendous migration of the top talent that used to be in the Executive Branch into the Legislative Branch.

That may not be of much concern to the Legislative Branch. I mean you are getting much better—you are getting great advise from people like Don Young and you have people like Karen Davis sitting on the Physician Payment Review Commission and others.

But there has been a tremendous brain drain. In fact, there are some staffers behind you who used to work in the Executive Branch who are now up here. There has been a tremendous brain drain out of HCFA and OMB, and certainly ASPE—Assistant Secretary for Planning Evaluations Office—has been dessimated in HHS.

Part of that has been there has been a rigorous ideological control on the debate in the Executive Branch. This has not, in the last eight years, been an Administration much interested in discussing new Federal initiatives or more detailed Federal management with regard to the health system. So I think that the policy staffs need to be rebuilt in HCFA and HHS because they have a very important role to play.

The second distinction I made about management, in there I think the salary structure is more important. As I said, I think the ideological climate in respect for policy thinking is most important for policy thinkers. I think for people who are oriented toward a management career, salaries and those kinds of authority that they can use is more important. And there I think we have to recognize that the Medicare program is one of the toughest management jobs in the country. I mean there is $120 billion and we are just beginning to touch on the complexities that the managers have to deal with on a day-to-day basis.

I think that—and I agree with Don—certainly at the entry level and the mid-career level, HCFA has suffered over the last five to eight years from inability to bring on and develop the new staff that are going to have to carry the program for the next fives years and carry it into the next century.

So I think that changing both salary and the whole climate of respect for Federal management as a career is essential for Medicare to be able to do its job.

Senator ROCKEFELLER. Dr. Lohr.

Dr. LOHR. We have had a decade or so of what one might call Civil Service bashing. It has got to be demoralizing from the top down through the lowest levels of the Civil Service. I would say that in some ways that must be at least as devastating to the leadership in the Executive Branch as short-term sort of non-changes, shall we say, in salaries.

And I hope that with the new Administration that will cease and that we will come again to recognize that there are rewards, psychic and otherwise, not just income, to public service and that that should be acknowledged.

I do not want to sort of downgrade the importance of income. But I think there is a dimension that I do not know if I heard mentioned that has to do with retirement in pensions and I think many civil servants—and people thinking to go into the Civil Service—look at how retirement benefits have been either mismanaged, chipped away at. There is great uncertainty about how one might plan for ones retirement, that I think can be at least as important as what my salary will be in the next two or three years.

A third point I would make with respect to the research agencies is that, if you do not provide for adequate research dollars, you get people not at absolutely the highest levels, but those who have to manage the research programs, very demoralized because they

cannot do a good job of funding the research grants, and cooperative agreements, and contracts that they would like to be able to fund to answer the questions that you are asking them to answer.

I would say one dimension of that is specifically Congressionally-mandated studies. It seems to me to put the research agencies in something of a bind when they have appropriated funds and a research agenda that they have laid out that makes sense to answer long-term questions and then to get hit with a variety of relatively expensive Congressionally-mandated studies, which means they have to take from their research agenda dollars to mount. And they are going to do the Congressionally-mandated studies before they do their own research agendas.

I would put in a plea that to the degree you want specific studies in two or three years, that the monies to conduct them be appropriated along with them.

Dr. MOON. I could not say it any better.

Senator ROCKEFELLER. Well then, let us bring this to a conclusion. I am tremendously grateful to all of you.

Medicare is a tremendously important program. It just really is. When I go home and see Appalachia and see the problems that people have—the needs are so real, just so desperately real. Then you come back here and you are faced with sequestration, Gramm-Rudman, shortages of this or that—read my lips, which is not a political comment, but simply no more revenues for at least this year—and nothing comes easily—nothing comes easily.

I really respect all of you for your work and we, in Congress, obviously really depend upon you for direction.

I am really happy about having this subcommittee. I am new to it. I have only been in the Senate for four years. This is my fifth year. The first two years I was not on Finance; therefore, I could not be on the health subcommittee, but I am digging in and plowing in with a very strong sense of public service. I really look forward to the work ahead and I think that this has been a very useful hearing.

Thank you very much.

[Whereupon, at 12:25 p.m., the meeting was concluded.]

APPENDIX

ALPHABETICAL LIST AND MATERIAL SUBMITTED

Opening Statement of Senator Lloyd Bentsen
Subcommittee on Medicare and Long Term Care Hearing
March 3, 1989

Mr. Chairman (Senator Rockefeller), I want to thank you for holding this hearing. As we begin a new Congress, it is important that we take a close look at the Medicare program to examine how it is operating and how well it is serving the health care needs of the nation's 32 million elderly and disabled. The Medicare program has gone through many changes in recent years, and it is a good idea to periodically reflect on how the program is working and where improvements can be made.

I know that this panel of expert witnesses that are assembled here have a wealth of knowledge and insight that they can share with us today concerning Medicare, and I look forward to hearing their testimony. We all need to work together to assure that Medicare beneficiaries have access to high quality health care, and to assure that beneficiaries and the Government are getting the best value for the $100 billion dollars that will be paid this year for health care under this program.

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Medicare: Its Use, Funding, and Economic Dimensions

Prepared at the Request of the
Senate Committee on Finance

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March 1, 1989
(With Revisions)

MEDICARE: ITS USE, FUNDING, AND ECONOMIC DIMENSIONS

INTRODUCTION

Medicare is a nationwide health insurance program providing benefits to 30 million aged and 3 million disabled individuals. In general terms, it is an acute-care insurance program. That is, while it provides coverage for most acute-care medical services, it does not provide extensive coverage for long-term care services, such as extended nursing home stays. The program consists of two separate but complimentary programs--each provides coverage for a different group of benefits and is separately financed. Part A, the Hospital Insurance (HI) program provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance (SMI) Program, covers physician services and a range of other outpatient health services.

Medicare expenditures have been rising rapidly. Benefit payments have been growing at the rate of 12.2 percent per year between 1980 and 1989. While expenditures under both parts rose rapidly in the early 1980s, enactment of the Prospective Payment System (PPS) for hospitals in 1983 slowed the rate of growth in Part A to only 4.6 percent per year between 1985 and 1989. Over the same period, expenditures under Part B, principly for physician services have continued to grow at a rapid rate, 15.5 percent per year. Given its size, the Medicare outlays represent a substantial portion of the Federal budget (7.6 percent of outlays in FY89) and of total national health expenditures (18 percent in calendar 1987). The magnitude of the Medicare program combined with its rapid growth raises a variety of issues, including the role of Medicare in deficit reduction efforts, whether the program is adequately financed now and in the foreseeable future, and the effects of continued growth on the Federal budget and the economy.

The authors would like to give special thanks to Ilene Shapiro for her assistance in preparing the charts and graphs used in this report.

I. HOW MEDICARE WORKS

As a health financing program, Medicare's purpose is to pay claims for services rendered to its enrollees by providers of health care. The program has two basic parts: Hospital Insurance (HI), sometimes referred to as Part A, pays claims for hospitalization and related nursing home and home health care. Supplementary Medical Insurance (SMI), sometimes referred to as Part B, pays claims for physician, outpatient, other auxiliary medical services, and for dialysis for those with end-stage renal (kidney) disease. New catastrophic benefits limit out-of-pockets costs enrollees must bare under both aspects of the program and for prescription drug expenses.

Most people gain eligibility for HI in the same way they do social security: by paying the HI tax while they work. The HI tax is part of the social security tax, sometimes referred to as the payroll tax. Working in

employment where the tax is levied gives a worker credit toward HI in the form of *quarters of coverage*. With a minimum number of *quarters*, an individual can become entitled to HI coverage at age 65 or after being on the social security Disability Insurance (DI) rolls for at least 2 years.[1] A spouse also can obtain coverage through the worker's earnings credits. The basic coverage is free, however, an *income-related* premium is now required of people eligible for HI *or who would be if they applied* to cover the costs of catastrophic protection. Aged individuals who are not otherwise eligible for HI may purchase coverage.

Eligibility for SMI does not require a work record. It is available on an optional basis to all resident citizens age 65 and older (and certain aliens) and to people who have been on the DI rolls for at least 2 years. Those who enroll must pay a fixed-rate monthly premium, part of which goes for basic coverage and another part for catastrophic protection. The basic portion is designed to cover only one-fourth of the program's non-catastrophic costs. The catastrophic portion together with a portion of the *income-related* premiums covers the full cost of the catastrophic protection.

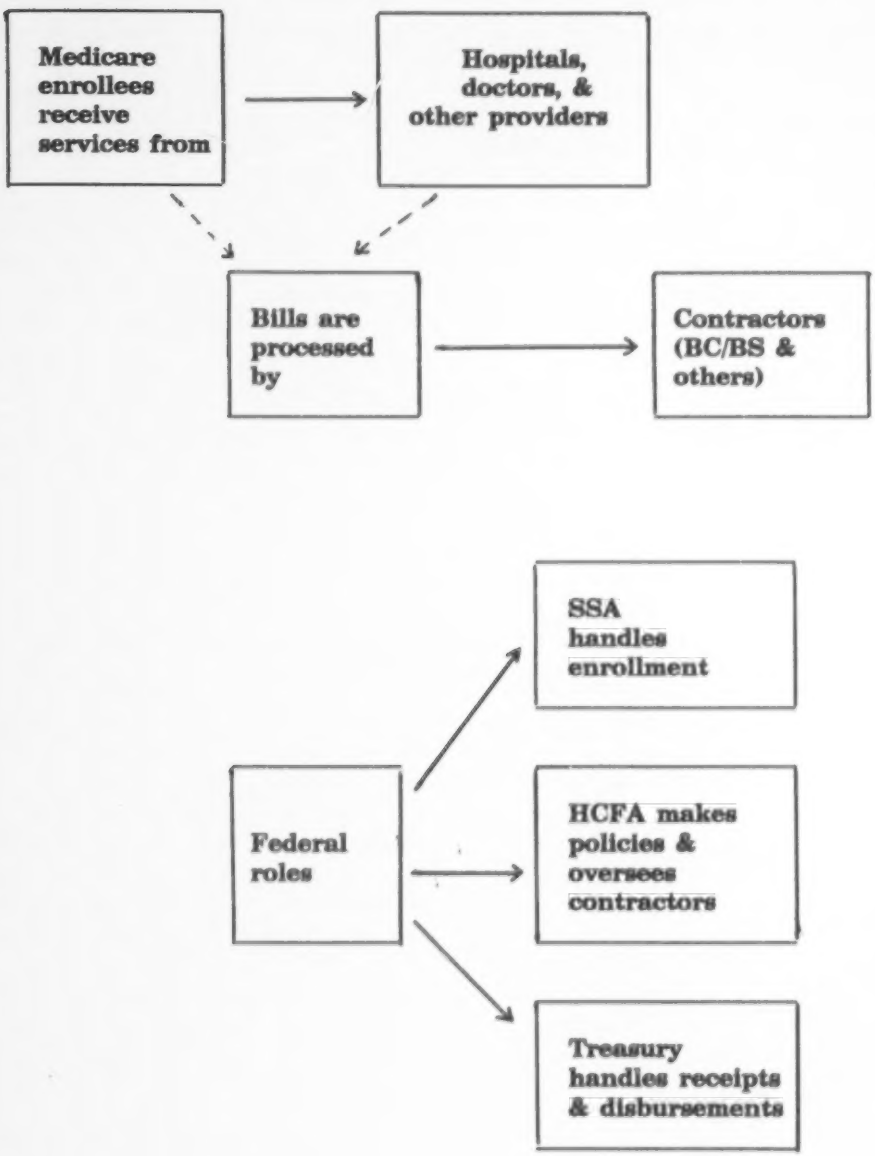
Various arms of the Government administer the programs: The Treasury Department has the tax collection and disbursement functions; the Social Security Administration (SSA) takes enrollment applications and serves as the first point of contact with the public; and the Health Care Financing Administration (HCFA), through its 88 contractors (Blue Cross/Blue Shield and other private insurers), operates the claims processing and program management side.

Some 32.6 million people are covered for HI services, and 32.5 million are covered by SMI. Approximately 6,700 hospitals, 7,400 skilled nursing facilities, and 5,800 home health agencies serve the enrollees.

In a broad sense Medicare is a multi-faceted Government-run money machine. In part it resembles a private insurance operation: it takes in premiums and provides protection to those who pay them. However, to a much larger extent, the program is underpinned by the principle that people finance the program while they work so that they may receive benefits when they retire or become disabled. In effect, they build credit toward their later eligibility. Moreover, while eligibility is earned, the money people pay is not set aside to meet their own health expenses. Instead, it is used to pay the health bills of those who are immediately eligible.[2] In a contemporaneous sense, this makes Medicare what economists call an "income-transfer" program, where income is taxed away from one group so that it can be redirected to another, presumably with a bias toward taking resources from those who have them and spending them on others in need. Taking the long view, it is an intergenerational transfer program where today's workers pay for the health expenses of their parents, with the expectation that their children will pay for theirs.

Thus, Medicare represents a blend of insurance and social welfare features. As such, it is called social insurance. The Government is the insurer, underwritten by its power to tax. The Nation's workers are a "mandatorily" insured group, but for protection that is deferred until retirement or disability occurs, and the current elderly and disabled populations are the immediate risk group.

CHART 1. HOW MEDICARE OPERATES


Medicare enrollees receive services from
Hospitals, doctors, & other providers
Bills are processed by
Contractors (BC/BS & others)
Federal roles
SSA handles enrollment
HCFA makes policies & oversees contractors
Treasury handles receipts & disbursements

II. BENEFITS

Medicare is a nationwide health insurance program providing benefits to 30 million aged and 3 million disabled individuals. In general terms, it is an acute-care insurance program. That is, while it provides coverage for most acute-care medical services, it does not provide extensive coverage for long-term care services, such as extended nursing home stays. As described in chapter I, the program consists of two separate but complimentary programs, each providing coverage for different groups of benefits. Part A, the Hospital Insurance (HI) program provides protection against hospital and related institutional costs. Part B, the Supplementary Medical Insurance (SMI) Program, covers physician services and a range of other health services including outpatient hospital services, physical therapy, diagnostic laboratory and X-ray services, and certain medical equipment. Beginning in 1990, under the provisions of the recently passed Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), coverage of outpatient prescription drugs is being phased in.

This section provides a basic description of Medicare's current scope of benefits under both Part A and Part B. This section also includes a separate brief discussion of how the benefits under each Part were changed by the Medicare Catastrophic Coverage Act (MCCA).

Part A Benefits

Inpatient hospital services. Medicare covers all expenses without limit for acute-care inpatient hospital services, subject to a single annual deductible ($560 in 1989) paid by the enrollee. Since October 1983, payments for inpatient hospital services have been made under the Prospective Payment System (PPS) for Hospitals. Under PPS, hospitals are paid a predetermined fixed price for each discharge that varies depending on the diagnosis of the patient. Hospitals also receive payments for certain other costs that are excluded from the PPS. While Medicare's payment may be higher or lower than the hospital's actual charges or costs, enrollees are not liable for any amount other than the annual deductible. There were 6,715 hospitals participating in Medicare in 1988. As described in the following section, hospital services account for the vast majority of benefit payments under Part A.

Skilled nursing home services. Part A provides coverage for up to 150 days per year in a skilled nursing facility (SNF) for patients requiring daily skilled nursing care. Such services include: nursing care; bed and board; physical, occupational and speech therapies; medical social services; drugs, biologicals, appliances and equipment furnished for use in the facility that are ordinarily provided by the facility; and certain other services. Stays in nursing homes by patients that do not meet the qualifying criteria or in nursing homes that are not certified by Medicare as an SNF are not a covered benefit. SNFs generally are reimbursed for their services on a reasonable cost basis, subject to certain limits. Enrollees are liable for a daily

coinsurance amount equal to 20 percent of the national average daily cost for SNF services for the first 8 days of SNF care in each year. The coinsurance amount for 1989 is $25.50 per day. Prior to January 1, 1989, SNF coverage was limited to individuals who were recently discharged from a hospital. This prior hospitalization requirement was eliminated by the MCCA. There were 7,379 SNFs participating in Medicare in 1988.

Home health services. Medicare provides unlimited coverage for home health care visits for beneficiaries who, as a result of their medical condition, are qualified to receive such care. To qualify, the individual must be confined to his or her home, and must be in need of intermittent skilled nursing care, or physical or speech therapy. As defined by law, Medicare home health services include: part-time or intermittent nursing care; physical, occupational or speech therapy; medical social services provided under the direction of a physician; to the extent permitted in regulation, the services of a home health aide; medical supplies and durable medical equipment, and certain other services. Both the HI and SMI programs provide coverage for home health services. Persons covered under both programs (the majority of enrollees) have payments for these services made under Part A. Persons enrolled in Part B but not Part A have their home health benefits paid under Part B. There is no limit on the number of home health visits covered, no prior hospitalization requirement, and no deductible or coinsurance charges to enrollees. Program guidelines generally limited daily home health care to 2 to 3 weeks. The MCCA clarified the extent to which intermittent skilled nursing care is covered on a daily basis. That is, the limit on consecutive days of care is raised to 38 days on January 1, 1990. Medicare pays for home health services on a per visit basis, subject to certain cost limits. There were 5,769 home health agencies participating in Medicare in 1988.

Hospice services. Effective November 1, 1983, Medicare covers stays in a hospice for terminally ill beneficiaries with a life expectancy of 6 months or less. Subject to certain limits, benefits under a hospice program include: home health services; outpatient drugs and biologicals; physician services; counseling with respect to care of the terminally ill patient and adjustment to his or her death; and short term inpatient care (in a hospital, skilled nursing facility or free-standing inpatient unit associated with the hospice) for pain control, symptom management, and respite care. Under Medicare, an enrollee who elects to receive hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Medicare payments for hospice services are made under a prospective reimbursement system and vary depending on the intensity of care provided each day. Payments also are subject to a cap per enrollee per year, $8,406 for the 12 month period ending October 31, 1988. Enrollees are liable for copayments for outpatient drugs and respite services. Coverage for hospice services is currently subject to a lifetime limit of 210 days. Beginning in 1990, coverage will be extended beyond this limit. There were 449 hospices participating in Medicare in 1988.

Part B Benefits

Physician services. Part B of Medicare provides coverage of physician services, including surgery, consultations, and office, home and institutional visits. This includes the services of licensed doctors of medicine and osteopathy. Under certain limited circumstances, the term "physician" is defined in Medicare law to include services provided by dental surgeons, podiatrists, optometrists, and chiropractors. Physician services are reimbursed on a fee-for-service, "reasonable charge" basis. That is, separate payments are made for each service, and Medicare determines a reasonable charge for each service. Generally, the reasonable charge is the smallest of the actual charge, the physician's usual charges for the service, and the prevailing charge for the service by other physicians in the same locality. Payments for these services, as well as payments for most other Part B benefits, are made at 80 percent of Medicare's reasonable charge and are subject to the $75 annual Part B deductible. Enrollees are liable for the deductible, a coinsurance payment equal to 20 percent of the reasonable charge, and in some cases for the difference between Medicare's reasonable charge and the physician's actual charge for the service. Payments for physician services account for over 70 percent of total benefit payments under Part B.

Medical and other health services. Part B also provides coverage for a wide variety of medical services that are known as "medical and other health services." Payments for these services are generally made on a reasonable charge basis, and enrollees are liable for the annual Part B deductible, 20 percent coinsurance, and in some cases the difference between Medicare's reasonable charge and the actual charge for the service. The rules for determining the reasonable charge vary depending on the specific service provided. As defined in the law, medical and other health services include: (1) outpatient hospital services; (2) diagnostic laboratory and X-ray services; (3) therapeutic radiology services; (4) outpatient occupational and physical therapy; (5) rural health clinic services; (6) services of clinical psychologists in certain settings; (7) kidney dialysis services including home dialysis supplies and equipment; (8) immunosuppressive drugs furnished in the first year following a Medicare covered transplant procedure; (9) durable medical equipment including prosthetic and orthotic devices; (10) services of certified registered nurse anesthetists (CRNAs); (11) services of physician assistants in certain settings; and (12) services in ambulatory surgical centers.

Effective January 1, 1990, the MCCA adds three new services to the scope of benefits under Part B. Mammography screening will be covered once every other year for women over age 65. Intravenous (IV) drug therapy services provided in the home will be a covered benefit. IV drug therapy services are defined to include nursing, pharmacy and related services. The cost of the IV drugs themselves will be covered under the new drug benefit described below. There are no Part B deductible or coinsurance for IV drug therapy services. Eighty hours of in home care for a chronically dependent individual would be covered for persons who meet either the catastrophic cap or the outpatient prescription drug deductible. This type of services is known as respite care

and is intended to relieve the routine caretaker (a spouse, family member, or other person living with the patient and providing daily care without pay) from the daily responsibility of caring for the chronically dependent individual.

Health maintenance organizations and competitive medical plans. Health maintenance organizations (HMOs) and competitive medical plans (CMPs) are organizations that provide health care services on a prepaid basis. These plans generally provide a specified scope of benefits in return for a fixed monthly premium known as a capitation payment. These organizations differ from traditional health insurance plans in that they not only perform an insurance function, but also directly provide or arrange for the provision of services. HMOs and CMPs may enter into so-called "risk-sharing" contracts with Medicare. Under these contracts, a plan may enroll Medicare enrollees and is paid a predetermined monthly capitation payment for each such individual. If the HMO or CMP provides services for less than the plan's capitation revenues, it keeps the residual as profits; if services to enrollees cost more than the capitation payments, the HMO or CMP loses money. Each participating HMO and CMP must provide, at minimum, the same benefits that are otherwise available under Medicare, including both Part A and Part B benefits if the enrollee is eligible for both Parts. These plans may, subject to certain limits, charge enrollees additional premiums, coinsurance, or copayment amounts. Persons enrolling in these plans agree to receive all covered services through the plans. Out-of-plan services are only covered on an emergency basis and are paid for by the HMO or CMP. Enrollees are liable for the cost of non-emergency out-of-plan services that have not been authorized by the HMO or CMP.

Cap on out-of-pocket expenses. Effective January 1, 1990, the MCCA provides for a maximum enrollee liability for the Part B deductible and coinsurance charges. After the cap is reached, Medicare would pay any coinsurance amounts due on Part B claims. Cost-sharing payments under Part A are not included under the cap and enrollees would still be liable for these amounts. The outpatient prescription drug deductible and coinsurance charges also are not included under the cap. The cap is set at $1,370 in 1990, and is indexed such that 7 percent of enrollees would exceed the cap in subsequent years.

Outpatient Prescription Drugs

Under the MCCA, an outpatient prescription drug benefit is to be phased in, beginning in 1990. In the first year, coverage is limited to home IV drugs and immunosuppressive drugs provided after the first year following a transplant; immunosuppressive drugs in the first year after a transplant are already a covered benefit under Part B. Reasonable charges for covered drugs vary depending on whether the drug is a single source or multiple source drug. Payments are subject to a $550 deductible in 1990, except that the deductible does not apply to home IV drugs initiated during a hospital stay. Coinsurance amounts are 20 percent for home IV drugs and 50 percent for immunosuppressive drugs. Effective January 1, 1991, the drug benefit

expands to include all outpatient prescription drugs subject to a $600 annual deductible and 50 percent coinsurance charges. The deductible changes to $652 in 1992, and in future years is indexed such that 16.8 percent of beneficiaries will reach the deductible each year. The coinsurance rate is slated to be lowered to 40 percent in 1992 and to 20 percent in 1993. The drug benefit is separately financed from other Part B benefits, and the Secretary has limited authority to implement special cost control measures in 1993 and 1994 if financing for the drug benefit is inadequate.

Exclusions

While Medicare covers most acute-care medical services, there are certain services that are specifically excluded. Explicit exclusions are provided for cosmetic surgery, routine physical checkups, services which constitute personal comfort items (e.g., a telephone during an inpatient hospital stay), expenses for custodial care, routine dental care, routine foot care, services that are paid for directly or indirectly by a governmental entity, and certain other specified services. In addition, there is a general exclusion for services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." This has been interpreted to exclude payment for experimental procedures or procedures whose value has not been proven. For example, Medicare does not pay for liver transplants for adults even though it would pay for the same service provided to enrollees who are under 18 years of age and who have certain medical conditions. With the exception of immunosuppressive drugs in the first year following a transplant, self-administered outpatient drugs have been excluded from coverage. However, coverage for these drugs will be phased in beginning in 1990 as described below.

Modifications to Medicare Benefits Due to the Catastrophic Health Insurance Benefits Act of 1988

The MCCA provides for changes to existing benefits and adds new benefits under Medicare (many already described). These include expanded coverage for institutional services under Part A as well as new benefits and an out-of-pocket expense limit under Part B. The only new benefits under MCCA that are already effective are the expanded coverage for inpatient hospital, SNF services, and hospice services. Most other new benefits will become effective on January 1, 1990. The outpatient drug benefit is being phased in, beginning in 1990. The following table summarizes the changes in Medicare's benefits under the MCCA.

TABLE 1. Capsule Summary of Major Benefit Changes in MCCA

Benefit	Before implementation of MCCA: Coverage/beneficiary charges	After implementation of MCCA: Coverage/beneficiary charges	Effective date
PART A			
Inpatient hospital services	--Per spell of illness a/ --First 60 days-deductible ($540 in 1988) b/ --61st-90th day-daily coinsurance ($135 in 1988) b/ --60 lifetime reserve days-daily coinsurance ($270 in 1988) b/	Unlimited number of days subject to 1 annual deductible ($560 in 1989) b/	1/1/89
Skilled nursing facility (SNF) services	100 days post-hospital care per spell of illness a/ --First 20 days-no coinsurance --21st-100th day-daily coinsurance ($67.50 in 1988) b/	150 days per year --First 8 days: daily coinsurance (25.50 in 1989) b/ --9th-150th day-no coinsurance	1/1/89
Home health services	No coinsurance Consecutive days of care limited to 21	Consecutive days of care limited to 38	1/1/90
Hospice	Lifetime limit of 210 days	Limit may be extended	1/1/89
Blood	Deductible-3 units per spell of illness	Deductible-3 units per year (reduced by any Part B blood deductible)	1/1/89

See footnotes at end of table.

TABLE 1. Capsule Summary of Major Benefit Changes in MCCA--continued

Benefit	Before implementation of MCCA: Coverage/beneficiary charges	After implementation of MCCA: Coverage/beneficiary charges	Effective date
PART B			
Physicians and other medical services	--$75 deductible on approved charges --20 percent coinsurance on approved charges --Beneficiary pays any amount above approved amount on unassigned claims ("balance billing")	Same, except limit ($1,370 in 1990) c/ on beneficiary deductible and coinsurance charges	1/1/90
Screening Mammograms	Not covered	Biennial screenings subject to payment limit and Part B coinsurance charges	1/1/90
Respite Care	Not covered	80 hours a year if the beneficiary reaches either the catastrophic or prescription drug limit; subject to 20 percent coinsurance charges	1/1/90
Home Intravenous Therapy	Not covered	Covered (drugs paid under drug benefit)	1/1/90

See footnotes at end of table.

TABLE 1. Capsule Summary of Major Benefit Changes in MCCA--continued

Before implementation of MCCA		After implementation of MCCA	
Benefit	Coverage/beneficiary charges	Coverage/beneficiary charges	Effective date
Outpatient Prescription drugs	Immunosuppressive drugs for 1st year after organ transplant-covered under regular Part B program	Same	
		Phase-in catastrophic prescription drug program:	
		Coverage	
		--Home intravenous (IV) drugs and immunosuppressive drugs after 1st year following an organ transplant	1/1/90
		--All outpatient prescription drugs	1/1/91
		Deductible d/	
		--$550	1/1/90
		--$600	1/1/91
		--$652 e/	1/1/92
		Coinsurance	1/1/90
		--20 percent for home IV drugs	1/1/90
		--50 percent for other drugs f/	

See footnotes at end of table.

a/ A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been an inpatient in a hospital or SNF for 60 days.

b/ Part A deductible and coinsurance amounts are increased annually. Before implementation of MCCA, SNF coinsurance was a percentage of the hospital deductible; after implementation of MCCA, it is 20 percent of estimated reasonable SNF costs.

c/ Amount indexed annually so that an estimated 7 percent of beneficiaries would be eligible for benefits each year.

d/ Does not apply for IV drugs furnished in connection with home IV therapy services initiated in the hospital.

e/ Amount indexed each year so that an estimated 16.8 percent of beneficiaries would be eligible for benefits each year.

f/ Coinsurance slated to decrease to 40 percent in 1992 and 20 percent thereafter.

III. EXPENDITURES AND USE OF SERVICES

Medicare is one of the fastest growing components of the Federal budget. Its share of total Federal outlays has risen from 3.9 percent in FY 1975 to 7.6 percent in FY 1989. The effects of rising Medicare costs on the Federal deficit and on the Medicare trust funds themselves are discussed further in section V. This section provides an overview of the trends in Medicare spending during the last decade and identifies some of the factors contributing to those trends.

General Trends

Table 2 shows the growth in program enrollment and payments during the 1980s. (The figures for FY 1990 are HCFA current law estimates and include the impact of the Medicare catastrophic legislation.) The growth of enrollment has been fairly steady in both parts A and B, averaging about 2 percent a year. Expenditure trends, however, are very different for the two programs. Costs for both parts were rising sharply in the early part of the decade, but the rate of increase in part A payments has moderated, largely as a result of the implementation of the PPS for inpatient hospital services in 1983. Part B costs, on the other hand, continue to grow rapidly.

Population growth plays only a minor part in increased program expenditures. More important are changes in the proportion of enrollees who actually use covered services, the quantity of services they consume, and the price Medicare pays for those services.

As table 2 indicates, the percentage of Part A enrollees using services has actually dropped slightly over the last 10 years. This may reflect the substitution of outpatient (Part B) services for inpatient hospital care, a phenomenon to be discussed later in this section. Under Part B, however, the proportion of enrollees receiving covered services has grown considerably. This is partly attributable to the fact that the Part B deductible, the amount an enrollee must pay for services during a year before Medicare will cover any charges, has been held at $75 since 1982, even though medical care prices were rising. This means that some enrollees whose charges during a year would once have been insufficient to meet the deductible may now, using the same amount of services, reach the $75 limit.

Finally, Parts A and B show different patterns of growth in the amounts paid for each enrollee using services. Early in the decade, payments per user rose at about the same rate under both programs, 13.2 percent for Part A and 12.5 percent for Part B. Part A growth has since dropped sharply, to 4 percent a year, again because of PPS. Annual growth in costs for users of Part B services has continued almost unabated.

TABLE 2. Medicare Enrollment and Payments, FY 1980-FY 1990

	1980	1985	1990[a]	Annual growth rate (%) 1980-85	Annual growth rate (%) 1985-90
Hospital insurance (Part A):					
Enrollees (thousands)	27,531	30,109	33,228	1.8	2.0
Payments (millions)	$23,776	$47,710	$63,069	14.9	5.7
Average payment per enrollee	$864	$1,585	$1,898	12.9	3.7
Number of enrollees receiving reimbursed services (thousands)	6,660	7,175	7,790	1.5	1.7
Percent receiving services	24.19%	23.83%	23.44%	-0.3	-0.3
Average payment per user of services	$3,570	$6,649	$8,096	13.2	4.0
Supplementary medical insurance (Part B):					
Enrollees (thousands)	27,120	29,781	32,778	1.9	1.9
Payments (millions)	$10,144	$21,808	$46,145	16.5	16.2
Average payment per enrollee	$374	$732	$1,408	14.4	14.0
Number of enrollees receiving reimbursed services (thousands)	17,787	21,227	26,581	3.6	4.6
Percent receiving services	65.59%	71.28%	81.09%	1.7	2.6
Average payment per user of services	$570	$1,027	$1,736	12.5	11.1
Total payments, Parts A and B	$33,920	$69,518	$109,214	15.4	9.5

[a]Current law projection, including proposed regulatory changes and effect of Medicare catastrophic legislation.

Source: Health Care Financing Administration.

Components of Part A and Part B Cost

Table 3 shows the breakdown by service type of Part A and Part B expenditures.

TABLE 3. Components of Medicare Expenditures, FY 1980-FY 1990

	1980	1985	1990[a]	Annual growth rate (%) 1980-85	Annual growth rate (%) 1985-90
Inpatient hospital	22,842	45,017	58,620	14.5	5.4
Skilled nursing facility	387	567	1,202	7.9	16.2
Home health	547	2,111	3,187	31.0	8.6
Hospice	0	15	160	0.0	60.5
Total Part A	23,776	47,710	63,169	14.9	5.8
Physician	7,814	16,789	31,275	16.5	13.2
Hospital outpatient	1,847	3,903	10,190	16.1	21.2
Other	483	1,116	4,680	18.2	33.2
Total Part B	10,144	21,808	46,145	16.5	16.2
Grand total	33,920	69,518	109,314	15.4	9.5

[a]Current law projection, including proposed regulatory changes and effect of Medicare catastrophic legislation.

Source: Health Care Financing Administration.

Under Part A, while inpatient services remain by far the most important component of spending, their share is expected to drop somewhat, from 96 percent in FY 1980 to 93 percent in FY 1990. Rapid growth in payments for skilled nursing facility services is expected, largely because the Medicare catastrophic legislation extended coverage and reduced coinsurance requirements for these services.

Growth in payments for home health services, once the fastest rising component of Part A spending, has slowed significantly for two reasons. First, payment limitations beginning in 1984 have reduced the annual growth in the average charge per visit from 10 percent a year during 1980-85 to 6 percent a year in the 1985-90 period. Second, the period of rapid growth in the use of Medicare home health services appears to have ended. Annual visits per enrollee quadrupled in the decade ended 1984, from 0.3 to 1.3, but have remained stable ever since. Finally, payments for hospice services, first covered in 1984, have been growing rapidly, although they remain an insignificant part of program expenditures.

Under Part B, the share of expenditures accounted for by physician services has dropped from 77 percent in FY 1980 to a projected 68 percent in FY 1990. Payments for outpatient hospital services, which were rising at about the same rate as physician payments in the first half of the decade, have since grown much more rapidly. This change, too, is partially attributable to the substitution of outpatient for inpatient services. For example, surgical procedures or diagnostic tests which would once have required a hospital admission may now be performed on an ambulatory basis.

The services labeled "other" in table 3 include some of the fastest growing components of Part B expenditures. Payments for independent laboratory services grew from $114 million in calendar year 1980 to $878 million in calendar year 1987, rising almost 34 percent a year. Payments for group practice plans, such as HMOs, grew nearly as rapidly, from $203 million in 1980 to $1,361 million in 1987.

Although the share of total Medicare expenditures accounted for by inpatient hospital and physician services has dropped somewhat, they remain the most important components of program expenditures and program growth. The remaining parts of this section look more closely at the trends in use and costs for these two major services.

Inpatient Hospital Services

For most of its history, the Medicare program paid for inpatient hospital care on a retrospective cost basis. Medicare paid in full the reasonable costs a hospital incurred in providing services to Medicare enrollees. Although attempts to contain the rate of increase in these costs began early in the 1970s, they were generally unsuccessful. By 1981, outlays for inpatient services were rising at an annual rate of 21 percent. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) imposed limits on the rate of increase in a hospital's costs for each case. A hospital whose costs rose faster than the target rate would be reimbursed only for costs below those limits. This change immediately reduced the rate of increase in Medicare inpatient costs to 10 percent between 1982 and 1983. The TEFRA limits were, however, a one way system. A hospital that failed to improve its efficiency could lose money, but any savings achieved by a hospital benefited only the Medicare program; the hospital could not share. The hospital

industry therefore initially supported the shift to the current PPS for inpatient services, established by the Social Security Amendments of 1983 (P.L. 98-21).

Hospitals included in PPS are paid a predetermined fixed payment rate, which varies depending on which of the approximately 470 Diagnosis Related Groups (DRGs) the patient has been classified into. The DRG payment is intended to cover the cost of treating the typical case in that DRG in a reasonably efficient hospital. Since hospitals are allowed to keep any difference between the PPS payment and their actual costs, PPS provides incentives for hospitals to contain costs, thus potentially reducing costs to the Medicare program. The new system was phased in over a 4 year period, beginning in FY 1984. Initially, each hospital's PPS rates were based largely on that hospital's historic costs. Now most hospitals are paid on the basis of national average rates.

Payment rates under PPS are adjusted to allow for differences among hospitals in the types of patients treated and services provided, through such mechanisms as an adjustment for teaching hospitals. The payment rates are also adjusted to account for differences in local hospital market conditions, through an area wage adjustment and different payment rates for urban and rural hospitals. PPS hospitals are also eligible for additional payments intended to cover certain additional costs of maintaining a hospital (e.g., capital-related costs such as interest expense, depreciation, etc.), operating special programs (e.g., medical education programs) or operating in special circumstances (e.g., serving low-income patients).

For the first 2 years, PPS rates were supposed to be "budget neutral," set at levels projected to result in the same annual increase in total Medicare inpatient expenditures as would have occurred under the previous system of TEFRA cost limits. Beginning in the third year, FY 1986, rates would increase according to an annual update factor established by the Secretary. This factor would take into account inflation, as measured by the market basket index, a gauge of the prices hospitals pay for the goods and services they purchase. The Secretary was also authorized to consider other trends, such as increased hospital efficiency or changes in medical technology. The final update factor could, then, be higher or lower than the rate of increase in the market basket index.

The 99th and 100th Congresses repeatedly postponed the Secretary's authority to set the update factor, and instead set the factors for FY 1986 through FY 1989 directly in legislation. (Under current law, the factor for FY 1990 and later years is to be equal to the market basket index.) As table 4 indicates, these update factors were below the market basket index. At the same time, however, the average Medicare payment per case rose faster than the update factors. This is because the update factor is not the only element affecting payment increases. For example, there have been changes in policies relating to add-on payments (such as those for medical education, disproportionate share hospitals, and capital costs). More important, there has

been a steady change in the kinds of Medicare cases hospitals have reported treating; each year, more cases fall into the higher-paying DRGs and fewer into the lower-paying ones. The "case mix index" shown on table 4 is a measure of this trend. Part of the change is real, reflecting hospitals' decisions to admit only more seriously ill patients while treating others on an outpatient basis, while part of the change results from improved accuracy in hospitals' reporting on their patients.

TABLE 4. Historical Trends in Factors Affecting the PPS Rates and Average Payments per Case (percentage change from the previous year)

	1982	1983	1984	1985	1986	1987	1988	1989	1990
Market basket index	8.3	5.9	4.9	4.1	3.1	4.5	4.7	5.4	4.7
Annual update factor					0.5	1.115	1.6	3.3	4.7
Case mix index			8.4	2.5	2.7	2.4	2.0	1.0	1.0
Average payment per discharge	14.0	10.4	10.4	14.9	7.1	4.1	2.9	3.8	7.7
Average payment per enrollee	15.4	11.7	7.2	6.3	2.9	1.8	2.4	4.7	9.0
GNP deflator	6.4	3.8	3.9	3.4	2.9	3.2	3.1	4.0	3.6

NOTE: Update factor for FY 1986 effective beginning with the eighth month of the fiscal year. Factors for FY 1988 and FY 1989 are weighted averages of the separate update factors for large urban, other urban, and rural areas, effective Apr. 1, 1988.

Source: U.S. Congress. House. Committee on Ways and Means. *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means.* [1989 volume in press.] Based on data from the Health Care Financing Administration.

While PPS was the major factor in moderating the growth in Medicare inpatient costs, other recent trends have affected the use of services by both Medicare and non-Medicare patients. The average length of hospital stays began declining in the late 1970s. Much of the decline in length of stay for the elderly occurred before PPS, although it accelerated slightly just after PPS was implemented in late 1983. A similar drop in length of stay was occurring for all patients, not just those over 65. Among the factors that may have contributed to earlier discharges are new technologies and changes in medical practice, the greater availability of home health services and other post-hospital care, and stricter utilization review by third party payers. More recently, length of stay for all patients has leveled off.

A second major change has been a drop in total hospital admissions. Admissions for younger patients were already declining in the early 1980s, at a time when those for patients over 65 were still rising. For those over 65, the drop did not come until the implementation of PPS. The decline in admissions for the Medicare population as a result of PPS was not anticipated. It had been thought that, in the face of limitations on revenues from each individual case, hospitals might admit more patients or admit some patients more than once. As noted earlier, however, hospitals apparently chose to treat some kinds of cases on an outpatient basis, admitting only the more severely ill as inpatients. This may explain why length of stay leveled off shortly after PPS was implemented. Although the fixed payment system gave hospitals a continued incentive to reduce length of stay, further reductions might not have been possible when hospitals began admitting more seriously ill patients.

The drop in total admissions for patients over 65 apparently ended in 1987. In 1988, admissions in this age group are estimated to have increased by 2.4 percent, approximately the same as the growth in the over 65 population. This may mean that admission rates are now steady, and that total Medicare admissions may be expected to rise in proportion to the size of the elderly population. As this change is very recent, however, it is too soon to know whether it is really the beginning of a long-term trend.

Physician Services

The increase in Part B expenditures for physician services is due to several factors. First, as noted earlier, the number of persons enrolled in Part B has been growing at a rate of approximately 2 percent per year. In addition, medical care prices have increased. The prices recognized by Medicare have increased somewhat more slowly than the rate of inflation in medical care prices in general, due in part to limits placed on increases in Medicare's allowed charges.

Medicare's basic fee-for-service payment system for physician services, modeled after reimbursement systems in use in the private sector, has remained relatively unchanged since the program's inception. Generally, separate payments are made for each individual service rendered. The price Medicare recognizes for each service is based on what is known as the

reasonable charge for the service. Medicare generally pays 80 percent of the reasonable charge. The patient is liable for 20 percent of the reasonable charge plus, in some cases, the difference between the actual charge and the reasonable charge.

The reasonable or approved charge for a service (in the absence of unusual circumstances) is the smallest of:

- the actual charge for the service by the physician;
- the physician's usual or customary charge for the service wherein the customary charge is usually defined as the median charge for that service by that physician during a preceding time period; and
- the "prevailing charge" for the same or similar services billed by all (or all similar) physicians in the locality (set at a level no higher than is necessary to cover the 75th percentile of physicians' customary charges for the service in the locality).

The customary and prevailing charge amounts are known as "fee screens" and are used to limit the amount Medicare pays for any individual service.

Before 1984, fee screens were updated annually on the basis of actual charges submitted by physicians in the preceding year. Since 1975, these annual updates have been subject to limits based on an economic index known as the Medicare Economic Index (MEI), which reflects changes in operating expenses and earnings levels of physicians. Physicians' actual fees generally have increased at a faster rate than this economic index. Between 1973 and 1984, the MEI increased by 106 percent while physician fees, as measured by the physician services component of the Consumer Price Index (CPI-U), increased 157 percent. Thus each year, an increasing percentage of physicians' actual and customary charges have exceeded the index-adjusted prevailing charge screens.

Since 1984, Congress has repeatedly acted to restrain increases in allowable physician fees. Physicians' customary and prevailing charges were frozen from July 1, 1984 through April 30, 1986: the annual update in the fee screens did not occur. Subsequent updates have been subject to congressionally mandated limits on MEI increases. Some categories of physicians or types of services have received special treatment. The first update after the freeze, on May 1, 1986, applied to "participating" physicians only (participating physicians are those who agree to accept Medicare's approved charge as payment in full). In later updates, participating physicians have been granted higher increases than non-participating ones. Higher increases have also been granted for primary care services, such as office visits, than for such services as surgical procedures. In addition to limiting the overall rate of increases in allowable charges, Congress applied special limits on payments for certain services believed to be relatively overpriced, such as cataract surgery and coronary artery bypasses. Finally, the Secretary

of Health and Human Services (HHS) may reduce charges not found to be "inherently reasonable," because the charges for a service are in excess of the estimated costs of the resources used in performing that service.

Largely as a result of congressional limitations, allowed charges for physician services under Medicare increased at a rate of about 5.5 percent per year over the 5 year period 1981-1986, as compared to about 9 percent per year for the physician services component of the Consumer Price Index. Increases in allowed charges per service, together with population growth, accounted for only about half of the annual rate of growth in physician payments over this interval.

The remaining growth in expenditures for physician services, often referred to as the "net residual" amount, is due to several factors including changes in the volume of services per enrollee, changes in technology, changing patterns of practice, and increasing intensity of care. In some cases, these changes may be related to increasing the quality of care or improving access to necessary services. On the other hand, some believe that not all of the increases in volume and intensity or changes in technology and patterns of practice are medically necessary and appropriate. That is, some portion of the "net residual" may represent unnecessary services that could be reduced or eliminated as part of an overall effort to control the growth in Part B expenditures.

Table 5 shows the shares of total allowed physician charges in 1987 attributable to different types of practitioners and different types of services. Surgery, the most important single component of spending, accounts for about the same share in 1987 as in 1980. However, there has been a shift in the performance of surgery from inpatient to outpatient settings. In 1987, allowed charges for surgery in outpatient departments and physicians' offices made up 46 percent of total allowed surgical charges, up from just 15 percent in 1980.[3]

The major change in recent years has been in expenditures for laboratory, radiology, and other diagnostic services. In 1987, diagnostic services accounted for 21 percent of total Part B expenditures (this figure includes expenditures for non-physician services), up from 15 percent in 1980.[4] The share of expenditures attributable to medical services, such as office and hospital visits, has declined proportionately. Part of this change may be due to the increased practice of "defensive medicine," the use of more diagnostic tests because of concerns about potential malpractice liability. The implementation of PPS for inpatient hospital services may also have had an impact. For example, hospitals often require a battery of diagnostic tests for each patient admitted. If these tests are performed on an inpatient basis, their cost is included in the

flat PPS payment for the case. If they are performed on an outpatient basis just before the admission, they are billable under Part B. (This "site shifting" is one of the factors considered by the Prospective Payment Assessment Commission and others in recommending PPS rate increases below the rate of inflation for the last several fiscal years.)

TABLE 5. Medicare Allowed Charges for Physicians' Services, by Type of Practitioner and Type of Service, 1987

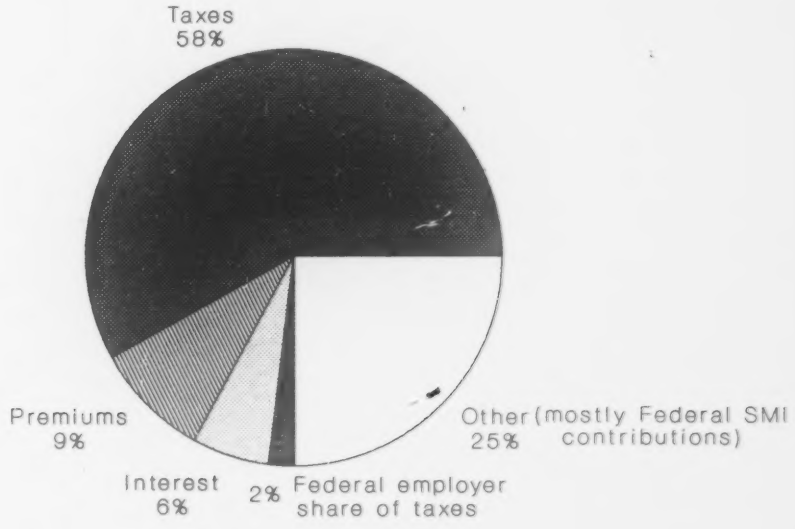
	Allowed amounts (millions)	Percent of total	Percent inpatient
Type of practitioner:			
Primary care physicians and clinics	$7,809	32.3	40.6
Nonsurgical specialists	3,989	16.5	56.3
Surgical specialists	8,717	36.1	48.6
Radiologists, pathologists and anesthesiologists	3,548	14.7	53.7
Osteopaths	87	0.4	26.4
Total	$24,151	100.0	47.9
Type of service:			
Medical care	$8,199	33.9	43.0
Surgery and assistance at surgery	8,805	36.4	57.9
Anesthesia	1,051	4.4	78.7
Diagnostic lab & radiology	4,187	17.4	31.1
Therapeutic radiology	351	1.5	11.5
Consultations	1,081	4.5	68.5
Other	477	2.0	10.3

Source: Health Care Financing Administration. Based on tables scheduled to appear in U.S. Congress. House. Committee on Ways and Means. *Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means.* [1989 edition in press.]

IV. FUNDING AND BOOKKEEPING

Unlike ordinary health insurance, Medicare does not rely on *prepayments* or premiums from enrollees. Instead, its primary income sources are Federal taxes levied on workers earnings (payroll taxes) and so-called *internal payments from the Government* (i.e., credits from one Government account to another). Premiums play a relatively small role. On an aggregated basis (HI and SMI combined) in fiscal year 1988, 58 percent of Medicare's financing came from payroll tax levies, 33 percent came from internal payments from the Government, and 9 percent came from premiums. Even with the introduction of additional premiums this year for coverage against catastrophic health expenses, aggregate premiums will still represent a small share of the program's total income.[5]

CHART 2. SOURCES OF MEDICARE INCOME, FY 1988



Note: HI and SMI combined.
Source: Office of Management and Budget.

Payroll tax receipts are the primary source of funding for HI. People who work pay the tax, with few exceptions. Even people who are currently enrolled in Medicare must pay it if they work. Thus, HI's costs are borne by virtually everyone who has earnings in the economy. Relying heavily on general resources of the Government, most of SMI's funding ultimately comes from income taxes and public borrowing. Thus, SMI's costs also are borne broadly within the economy, although through very different means than HI. In contrast, the costs of the catastrophic protections--funded entirely through premiums--are borne exclusively by those who are eligible, largely the aged.

The receipts and expenditures of the program are accounted for through separate trust funds that are maintained by the Treasury Department. However, the trust funds themselves do not actually provide the program's financing. Money received and spent for Medicare purposes is through the general treasury. The trust funds hold non-marketable Federal securities. When the Government receives revenues on behalf of the program, the Treasury Department posts securities to the appropriate trust fund. As payments are made from the treasury for the program, the balance of securities recorded in the trust funds is reduced. In effect, the receipts and outgo of the program occurs through the Federal treasury and is reflected by a rise or fall in the securities balances of the trust funds. As long as there are balances posted to the trust funds, the Treasury Department is authorized to make expenditures on the program's behalf.

HI Financing Sources

HI's financing is very similar to that of the social security programs. Its primary source is taxes under the Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA), commonly referred to as FICA and SECA taxes. In 1988, 90 percent of HI's income came from these taxes.

The FICA tax is a flat-rate tax on earnings of wage and salary workers (i.e., people in the employ of others). It is paid by workers with a matching amount paid by their employers (the employer is responsible for withholding and submitting both its own and its employees' shares). The SECA tax is a flat-rate tax on net self-employment income. There is a limit on the amount of earnings that can be taxed in a given year ($48,000 this year); thus, not all earnings are necessarily taxed. Moreover, neither the FICA nor SECA tax is levied on non-work income, i.e., dividends, interest, capital gains, or other forms of investment income. Only earnings from work are affected.

The other 10 percent of HI's income comes (1) from credits from the Government itself in the form of interest earned on non-marketable securities held by its trust fund--the HI trust fund--and reimbursement for various other purposes, and (2) premiums paid by people not otherwise eligible.

The HI tax rate. Today, the FICA tax rate is 7.51 percent, 15.02 percent when the employee's and employer's shares are combined; the SECA

rate also is 15.02 percent, but the law provides a 2 percentage point credit that effectively lowers the rate to 13.02 percent. Both FICA and SECA taxes have three components: two are for the social security programs of Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) and the third is for HI. The HI component is 1.45 percent for the employee and employer each (2.9 percent on a combined basis) and 2.9 percent for the self employed. Wage earners, salaried workers, and their employers account for about 95 percent of HI tax receipts; the self employed account for the other 5 percent. About 19 percent of FICA and SECA receipts is allocated to HI.

Although increases in the social security portions of the tax rates are currently scheduled to take effect in January 1990, the HI portions are fixed in the law for the indefinite future.

TABLE 6. FICA and SECA Tax Rates under Current Law

	FICA			SECA			
	OASDI (employee/employer each)	HI (employee/employer each)	Total (employee/employer each)	OASDI	HI	Credit	Total
1988-89	6.06	1.45	7.51	12.12	2.9	(2.0)	13.02
1990	6.20	1.45	7.65	12.40	2.9	*	15.3*

* The self-employment credit expires at the end of 1989, but beginning in 1990 self-employment taxes will be computed on a lower net earnings basis and half of SECA taxes will be deductible for income tax purposes.

The taxable earnings base. FICA and SECA taxes are levied on earnings up to an annual ceiling or cap known as the taxable earnings base. Earnings above the base are not taxed. Usually, payment of FICA and SECA taxes commences at the beginning of a calendar year and continues throughout the year until the cap is reached. Thus, someone whose earnings reach the cap by July would stop paying the tax at that point and would not resume paying it until the beginning of the next year.

Starting at $3,000 in 1937 (when the social security tax was first levied), the base has been increased 23 times and stands at $48,000 in 1989. When the HI portion of the tax was first levied in 1966, the base was $6,600. It has been raised 19 times since then. Under current law, an increase in the base is triggered whenever social security recipients are granted an automatic cost-of-living adjustment (COLA). Earnings base increases have occurred annually since 1972, although many of the hikes were not automatic. Since

1982, the increases consistently have matched the growth in average earnings in the economy. The base is projected to rise to $65,700 by 1995.[6]

Most workers pay the HI tax on all their earnings. In 1986, an estimated 94 percent of workers who were required to pay the HI tax in 1985 had annual earnings below the taxable earnings base, and 91 percent of all earnings in covered employment was taxable (up from 88.5 percent in 1980 and 78 percent in 1970).

HI "buy-in" premiums. Although a minor income source, premiums are paid by people who buy HI coverage. People age 65 and older who are not otherwise eligible for HI, i.e., they do not have sufficient *quarters of coverage* or do not have a spouse who has earned eligibility, can purchase HI for a monthly premium. The premium is $156 a month during 1989 ($1,872 on an annual basis). It will be increased automatically in future years. Premiums represented only 0.1 percent of the program's aggregate income in 1988.

The 1989 premium is lower than the 1988 level of $234 a month. This was done as part of the new Medicare catastrophic provisions to better reflect the costs to the program. The procedures used prior to the change tended to overstate the actuarial value of the program. The new procedures tie the premium to *the average per capita amount payable from HI for aged enrollees*.

Interest on securities and other internal payments. Also providing financing to the program are interest on securities held by the HI trust fund and other internal credits from the Government. The other internal credits are for the costs of HI benefits provided to certain uninsured individuals,[7] and those resulting from gratuitous wage credits given to military personnel. Interest is by far the largest of these internal payments, comprising 8 percent of all income posted to the HI trust fund in 1988.

SMI Financing Sources

In contrast to HI, the SMI program does not rely on payroll taxes. General resources of the Government are its principal source of funding with monthly premiums paid by people enrolled in the program accounting for most of the remaining portion.

SMI standard monthly premiums. SMI is voluntary; most people 65 and older can enroll in it regardless of whether they elect HI coverage or social security benefits.[8] When the program began in 1966 monthly premiums paid by enrollees were set in the law to finance half of the program's costs. Over the years, however, the premium's growth did not keep pace with the rapidly rising costs of the program. As a result, the basic program (i.e., the non-catastrophic portion--see following description of *catastrophic protection financing sources*) currently receives only one-fourth of its financing from premiums.

Annually, the Secretary of HHS determines what the basic or so-called standard monthly premium will be, based on the projected costs to be incurred by enrollees age 65 and older for the year in which the premium will be in

effect.[9] For the past few years, the law required that the standard premium be set so that aggregate premium receipts cover 25 percent of the aged's SMI costs. Thus, the premium rose roughly in tandem with program costs. However, beginning in 1990 the law reinstates a limit on how much the premium can rise--a limit that was in effect prior to 1984. It will preclude the premium from rising at a faster rate than social security COLAs. The COLAs are based on the general level of inflation in the economy as measured by increases in the CPI. If SMI costs continue to rise faster than the overall CPI after 1989, the share of the program financed through premiums will decline again.

TABLE 7. Level of Standard SMI Premiums, 1966-89

Calendar year	Standard monthly premium	Annual cost to enrollee	SMI premium income as % of total SMI income
1970	$5.30	63.60	49.8%
1980	9.60	115.20	27.7
1985	15.50	186.00	22.4
1989	27.90*	334.80*	25.4

* These figures exclude the new catastrophic coverage premium; which for most SMI enrollees is $4.00 a month. This *add-on* makes the 1989 SMI premium $31.90 a month.

Source: Derived from 1988 SMI trustees' report and supplemented by data from the Health Care Financing Administration.

Government contributions to SMI. The Government, through internal credits to the SMI trust fund, matches the standard premiums paid by enrollees (the non-catastrophic portion) with so-called "Government contributions." In contrast to the single premium level applicable to all SMI enrollees, separate matching rates are determined for the aged and disabled (including enrollees suffering from end-stage renal disease) based on the projected costs to be incurred by each group. The matching rates are basically intended to cover the difference between the premium income and costs of the program. Appropriate adjustments are made to reflect interest earnings and the amount needed to maintain an adequate contingency reserve in the SMI trust fund.

Government contributions are the largest source of financing for the program. The Government's matching rate grew steadily from a little more than one-to-one in the early years of the program to roughly three-to-one by the early part of this decade. In recent years the rate has remained fairly steady as a result of repeated congressional action to hold it at the three-to-one level for the aged. However, after 1989, when the law will again limit the premium increase to the percentage increase in social security COLAs, the rate will resume growing if SMI costs continue to rise faster than the overall cost of living--i.e., the Government's share will start rising again.

Interest on securities. Interest on securities held by the SMI trust fund also provides financing to the program. As with interest earned by the HI trust fund and the Government's contributions to SMI, SMI's interest is

basically an internal credit from the Government. It has never been a major factor in financing the program. At its peak in 1985, it was equal to roughly 5 percent of SMI expenditures. In 1988, it was equal to only 2 percent.

Catastrophic Protection Financing Sources

New Medicare protection against unusually large health expenses--so-called catastrophic expenses--was enacted with passage of the Medicare Catastrophic Coverage Act of 1988 and is being phased in over a 5 year period beginning in 1989. It improves the benefits provided through HI (beginning in 1989) and SMI (beginning in 1990) by affording broader coverage of health expenses and placing limits on the out-of-pocket costs enrollees pay for medical goods and services. In addition, in 1991 the program will begin phasing in prescription drug coverage (very few prescription drug costs were previously covered). The enactment of these benefits introduced a new concept in the financing of the program: the costs were to be borne entirely by the recipient population.

There actually are two components of the new financing, both of which are in the form of premiums paid by those who are eligible for or enrolled in Medicare. Envisioned in the legislation is that, at least to start, 63 percent of the financing would come from an income-related premium--basically a surtax on the income tax liabilities of the affected population. CBO estimates that about 36 percent of Medicare enrollees will pay it in 1989, rising to 42 percent by 1993. The remaining 37 percent would come from a flat-rate monthly premium added to the standard SMI premium. Each of these premiums is divided into (1) a basic catastrophic component and (2) a prescription drug component. Congress intended that together these new premiums would fully cover the costs of the new benefits.

Supplemental premiums. An income-related premium--referred to as the supplemental premium--is mandatory for people who are (1) enrolled in HI for at least 6 months during the year or (2) even if they are not enrolled, would be eligible if they did. This encompasses most of the population 65 and older and those people eligible for Medicare because they have been receiving social security disability benefits for 2 years or more. The premium is derived from their income tax liabilities. In 1989, the premium is $22.50 for each $150 of income tax liability incurred, up to a maximum premium of $800 for the year ($1,600 for a couple when both are eligible). In effect, the premium amounts to a surtax of 15 percent (up to a dollar limit). The law specifies larger premium levels for 1990 through 1993 that effectively impose progressively higher surtaxes.

TABLE 8. Income-Related Catastrophic Premiums, 1989-93

Calendar year	Premium per $150 of tax liability	Implicit surtax rate	Maximum potential premiums for individual	Maximum potential premiums for couple[10]
1989	$22.50	15%	$800	$1,600
1990	37.50	25	850	1,700
1991	39.00	26	900	1,800
1992	40.50	27	950	1,950
1993	42.00	28	1,050	2,100

For years after 1993 the law prescribes procedures for raising the premium rate if necessary to help keep new premium income and expenditures in line. The new income would be expected to rise as the affected population's tax liabilities rise, but if the new expenditures rise faster--as determined by measures of actual recent per capita experience of both, *not projections*--the Secretary of Health and Human Services (HHS) is required to raise the premium rate accordingly. Additional adjustments are required to reflect the recent inflation rate (the latter serving primarily as an added contingency margin in the event inflation accelerates) and to maintain adequate balances in new trust funds created for the expanded coverage. The premium rate cannot go up by more than $1.50 in any year (per $150 of tax liability), and if that precludes the new premiums from rising in tandem with the new expenditures, the new flat-rate premium is to be increased to make up the difference.

Flat-rate catastrophic premiums. The new flat-rate catastrophic premium is an add-on to the standard SMI premium. It is not mandatory in

the same way as the income-related premium. It must be paid only if an individual is actually enrolled in SMI. The law explicitly establishes the premium levels for 1989 through 1993.

TABLE 9. Flat Rate Monthly Catastrophic Premiums, CY 1989-93

Calendar year	1989	1990	1991	1992	1993
	$4.00	$4.90	$7.40	$10.20	$10.20

*Alternative pre-set premiums are established for (1) residents of Puerto Rico and other U.S. Commonwealths and territories, (2) for people enrolled in Part B only, and (3) for those who buy into HI.

As with the income-related premium, for years after 1993, the law specifies procedures for indexing the flat-rate premium in order to keep the costs and financing of the new benefits in balance.[11] If necessary, additional adjustments are required to make up for any potential revenue loss caused by limitations on how much the income-related premium can be raised.

Medicare Trust Funds

Medicare's financial operations are accounted for through four trust funds and a special catastrophic coverage account, all of which are maintained by the Department of the Treasury. Two separate trust funds have existed since the beginning of the program for HI and SMI and two additional funds were created this year for the new catastrophic benefits: one for the new drug-related benefits and another for the expansion of HI protections. In addition, a special catastrophic coverage account--referred to as *the Account*--has been established to separately keep track of the full range of new HI and SMI receipts and expenditures.

Three out of four of these trust funds reflect both income and outgo flows. One, however, a new HI catastrophic coverage *reserve fund*, reflects only income flows. Expenditures recorded against the basic HI and SMI trust funds include their standard benefits and expenses and, as well, their respective shares of the new catastrophic costs. HI payroll tax receipts and other internal payments from the Government are credited to the HI fund, however, HI's share of the new catastrophic premiums are credited to the new reserve fund. All of the new income-related premiums (the non-drug portion)

are first credited to the reserve fund, and then, to the extent these premiums exceed HI's new catastrophic-related expenditures, they are credited (or transferred) to the SMI fund. The law currently does not permit any transfers from the reserve fund to the HI fund to recognize the new HI expenditures, however, the conference report accompanying the new law states that the conferees anticipated that Congress "may at some future time transfer funds from the reserve fund to the HI trust fund to bolster the solvency of the fund."[12] The standard SMI premiums, the Government's matching contributions and other internal payments, and the new catastrophic "add-ons" to the standard SMI premiums are all credited to the SMI trust fund. Beginning in 1990, the Catastrophic Drug Insurance fund will be credited with its shares of the income-related and flat-rate premiums.

The new catastrophic coverage *account* is not credited or debited with receipts and expenditures in the same way as the various trust funds--Federal securities are recorded to the trust funds; but not to this account. It serves as a centralized means of keeping track of catastrophic receipts and expenditures overall and the separate HI and SMI components. Its primary function is to be a record keeping device for measuring whether and by how much the new catastrophic premiums need to be raised.

The trust funds themselves are not actually repositories for money. In a sense, like the new catastrophic coverage *account*, they are record keeping devices. When it is said that one or another of them receives income what is being described is the crediting of securities to them by the Treasury Department. However, the money received by the Government (payroll taxes and premiums) and the money spent by the Government to pay claims and administrative expenses moves in and out of the treasury along with other governmental receipts and payments. As Medicare taxes and premiums are paid into the treasury, a corresponding amount of new securities is posted to the trust funds. Similarly, when internal credits from the Government are due to the trust funds--e.g., for interest on securities held by the funds--new securities are posted to them. Conversely, when Medicare expenditures are made, the money is paid out of the treasury and a corresponding amount of securities is deleted from the trust funds.

In any given accounting period, income posted to the trust funds (the new securities) is always a larger figure than the actual Medicare receipts the Government takes in. Interest income, for instance, is not derived from sources outside of the Government, since the trust funds only hold securities of the Government itself. Interest is simply a credit from one Government account to another. The Government's SMI contributions are similarly just internal transactions; the securities of the SMI trust fund are raised when that posting is made, but the Government has not actually received any new money.

The securities held by the trust funds function like a checking account balance. As long as there are securities in the funds, the Treasury Department has authority to write checks to meet the program's commitments. This is in contrast to many other Government programs where Congress must give express approval each year to keep payments flowing by enacting appropriations laws. The balances of the trust funds, in a sense, provide indefinite approval to spend on behalf of the program.

V. POSITION IN THE ECONOMY[18]

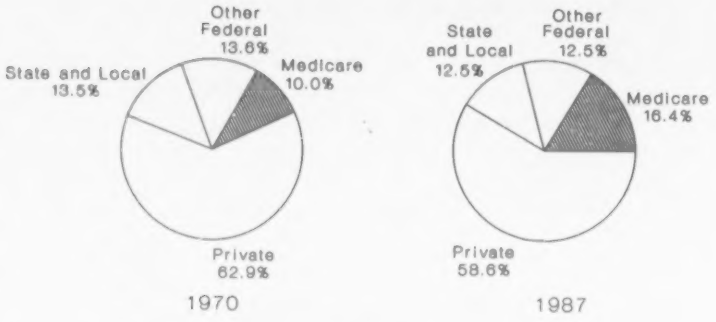
How significant is Medicare in the economy? How much does it finance of what the Nation spends on health? How much do the Nation's hospitals, doctors, and other medical providers receive from it? What is its share of the Federal budget and the amount the Government spends on health programs? How much do its enrollees depend on it? And how big of a tax bite does it take? Simply put, how big is Medicare as a financial institution?

Medicare As a Part of The Overall Economy

In 1987, expenditures made in the U.S. economy for health-related services and activities were $500 billion, or 11.1 percent of the Gross National Product (GNP). In lay terms, $1 out of every $9 spent in the economy was for health purposes. This represented more than a three-fold rise in dollar terms from 1965 (in constant 1987 dollars), and nearly a doubling of the share of the Nation's spending directed at the health sector. Moreover, projections suggest sizeable future growth, with health spending increasing by 200 percent by the year 2000 and accounting then for nearly $1 out of every $6 of GNP. Medicare has been part of and is expected to remain a contributor to this growth. By itself the program represents a notable element of the economy with expenditures equaling 1.8 percent of GNP (in 1987). Its payments account for one-sixth of national health expenditures with their greatest impact being in the hospital sector where the program pays for almost 30 percent of the services provided. It has a similar marked impact on physician services where it finances $1 out of every $5 of care.

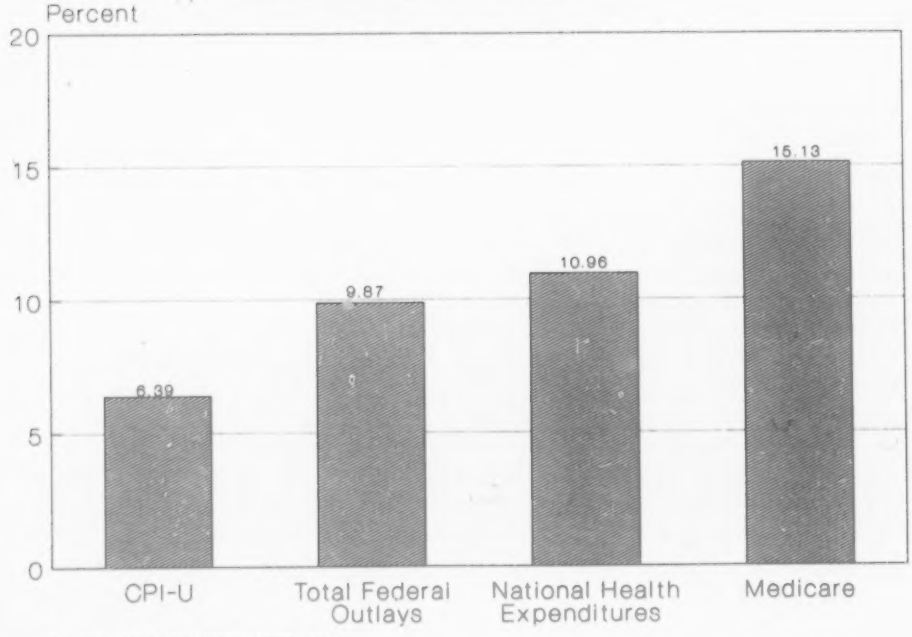
Thus, in a little more than 2 decades Medicare has assumed a major role in financing the Nation's medical care. Implemented in 1966, the program's spending grew at an average annual rate of 15 percent from fiscal year 1970 to 1988 (11.9 percent from 1980 to 1988). This was a faster pace than the overall inflation rate (as measured by the CPI), wages in the economy, GNP, and national health expenditures generally.

CHART 3. MEDICARE'S SHARE OF NATIONAL HEALTH EXPENDITURES 1970 AND 1987



Source: Dept. of HHS and Medicare trustees' reports.

CHART 4. MEDICARE'S RATE OF GROWTH COMPARED TO OTHER ECONOMIC MEASURES, FY 1970-88 (average annual growth rate in percent)



Source: Derived from HCFA date.

While Medicare's rate of growth has moderated some in recent years, current projections suggest that the program will continue to grow faster than GNP, and by 2000 its expenditures would exceed of three percent of GNP--representing more than a 50 percent increase.[14] Moreover, these projections do not reflect the impact of the new catastrophic provisions, which may increase Medicare expenditures by 7 percent or more.[15]

TABLE 10. Projected Average Annual Growth Rate of GNP, National Health Expenditures, Federal Health Expenditures, and Medicare, 1986-2000

Projected average annual growth rate in percent 1986-2000			
GNP	National health expenditures	Federal health expenditures	Medicare
6.5	9.0	9.8	10.8

NOTE: Figures do not reflect new catastrophic expenditures.

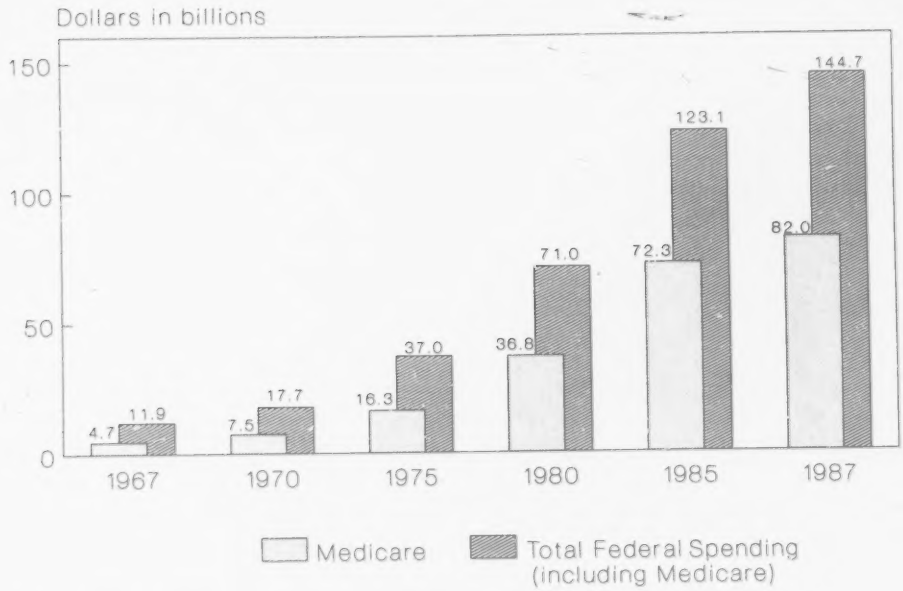
Medicare As a Federal Health Program

In 1965 the Federal Government accounted for 13 percent of the Nation's health spending; by 1987, its share had grown to 29 percent. The entire amount of that growth can be attributed to Medicare. In 1987 Medicare's expenditures accounted for 57 percent of all Federal health spending (up from 42 percent in 1970) and nearly 17 percent of national health expenditures (up from 10 percent in 1970).[16]

Prior to the advent of Medicare and Medicaid in 1965, the Federal Government had a relatively modest role in paying for personal medical services, which was mostly confined to veterans and the military. Its presence was more pronounced in the medical research, hospital construction, and public health fields. However, from 1965 to 1987, the Government's share in

the financing of personal medical care rose from 10 to 30 percent, while the combined shares paid by individuals and private insurers dropped from 78 percent to 60 percent. Medicare was the dominant factor in that growth, with the means-tested Medicaid program running second.

CHART 5. MEDICARE'S SHARE OF FEDERAL HEALTH EXPENDITURES, 1967-87

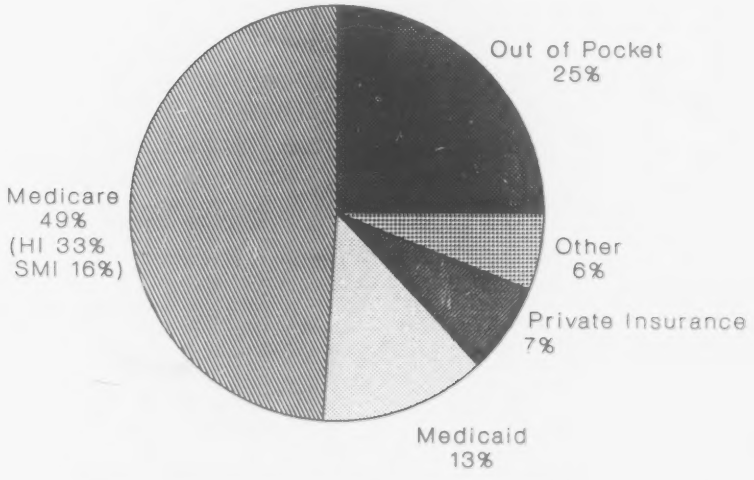


Source: Derived from National Health Expenditure data.

Medicare's Insurance Value for its Recipients

In 1984, 97 percent of the population 65 and older was covered by one or both parts of Medicare and nearly 70 percent of these enrollees were served by the program--i.e., Medicare payments were made on their behalf or to them directly. The program is not a source of cash income to the aged in the same way social security, earnings from work, or private pensions are. It does not provide regular periodic payments, not everyone enrolled in it receives reimbursement every year, and when reimbursement does occur it can vary widely depending on utilization. However, Medicare has substantial value to the aged as a source of insurance. While the aged comprise about 12 percent of the population, they account for nearly one-third of the Nation's expenditures for hospital care and one-fifth of those for physician care. Overall, Medicare payments covered almost 50 percent of the per capita health expenditures incurred by people 65 and older, with an equivalent value of 20-25 percent of their reported money income for the year.[17]

CHART 6. SOURCE OF FINANCING OF ELDERLY'S MEDICAL COSTS, 1984



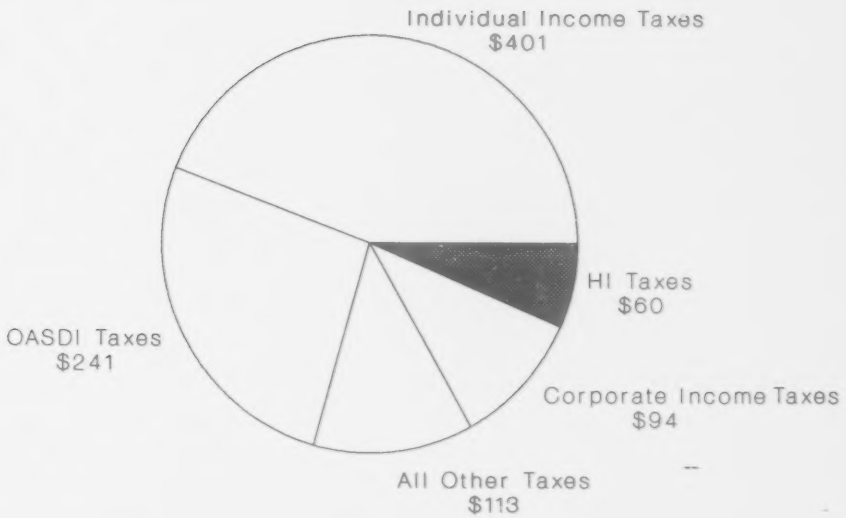
Source: Waldo and Lazenby. Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984.

Medicare As a Federal Tax

As have social security and other forms of Federal social insurance taxes, Medicare receipts have become a very substantial source of Federal revenues. In FY 1988 HI taxes of $60 billion make up 18 percent of the $334 billion in social insurance taxes and contributions collected by the Government and 6.6 percent of the $909 billion in total Federal receipts (excluding public borrowing). SMI premiums added another $8.8 billion although they are treated by the Treasury as offsets to outlays (most are deducted directly from social security recipients' checks). Overall, Medicare was the Government's fourth largest source of receipts.

The HI tax is broad based, with more than 95 percent of the workforce required to pay it. The only major group still exempted are employees of State and local governments who have been with their respective government employers since March 31, 1986, and have not elected social security or HI-only coverage. Federal workers were mandatorily covered in 1983.

CHART 7. HI AS A SOURCE OF FEDERAL FINANCING, FY 1988 ($'S in billions)



Source: Final Treasury statement for FY 1988.

The HI tax is a flat-rate tax on earnings from work. Thus, low wage earners pay less than high wage earners. A person earning minimum wages (about $7,000 per year) pays only $100 in HI taxes (excluding the employer share). A person earning over $48,000 per year pays about $700 in HI tax. A person with average earnings ($20,000) pays $290.[18]

From the perspective of how much the tax weighs on families at different income levels, data derived from a Congressional Budget Office (CBO) study shows that 80 percent of social insurance taxes, of which HI taxes are a part, are paid by families in the upper half of the income spectrum (above $26,000 annually in 1988 dollars), with 25 percent coming from those in the highest 10 percent (above $68,000 annually).[19] However, these taxes represent a smaller share of the total Federal taxes they pay than it does for those in the lower half. As shown in table 11, for persons at the lowest income levels, the HI tax represents about 10 percent of Federal tax liability. The HI tax represents only 4 percent of Federal tax liability for persons in the highest income category. This is due in part to the fact that social insurance taxes are levied only on wages, and wages are a greater share of the income of people in the lower half of the income spectrum, and because income taxes have an increasingly greater effect on the higher income brackets.

TABLE 11. Significance of HI Tax as a Federal Tax, by Income Level

Income levels	HI taxes as a percent of the total 1988 Federal taxes paid by people in the:
lowest 10th	9.3%
2nd "	12.4
3rd "	11.8
4th "	10.4
5th "	9.7
6th "	9.3
7th "	8.9
8th "	8.9
9th "	8.2
highest 10th	4.1

Source: Derived from distributional data on social insurance taxes contained in the CBO study, *The Changing Distribution . . .* , loc. cit.

While the HI tax is a more significant form of Federal taxation for people in the lower half of the income spectrum, the effective HI tax bite is still small. According to the CBO study, HI taxes absorb only 1 percent of the incomes of families in the lowest tenth of the income spectrum, with the figure rising to no more than 2 percent for those with average incomes. The smaller percentage at the lower levels is due to the fact the nontaxable transfer payments are a major income source for families in those income brackets. A much more significant bite is taken by social security retirement and disability taxes and Federal excise taxes.

VI. RELATIONSHIP TO THE FEDERAL BUDGET

Medicare's Growing Position in The Budget

Currently, Medicare is counted in the Federal budget. With FY 1988 outlays representing 7.4 percent of Federal spending, and revenues representing 6.6 percent of Federal tax receipts, Medicare has acquired a significant position in the budget.

Rapid growth of entitlement programs caused spending on human resource programs to jump from 33 percent of Federal outlays in 1968 to almost 55 percent 10 years later.[20] While the human resource share has since leveled out at about 50 percent, Medicare's spending has continued to surge. Its share of Federal outlays rose from 3.9 percent in 1975 to 5.4 percent in 1980 to 7.4 percent in 1988, making the program one of the fastest growing segments of Federal spending. Coupling this rapid growth with the financial strain caused by large overall deficits, proposals to constrain Medicare spending have been high on the list of congressional budget options.

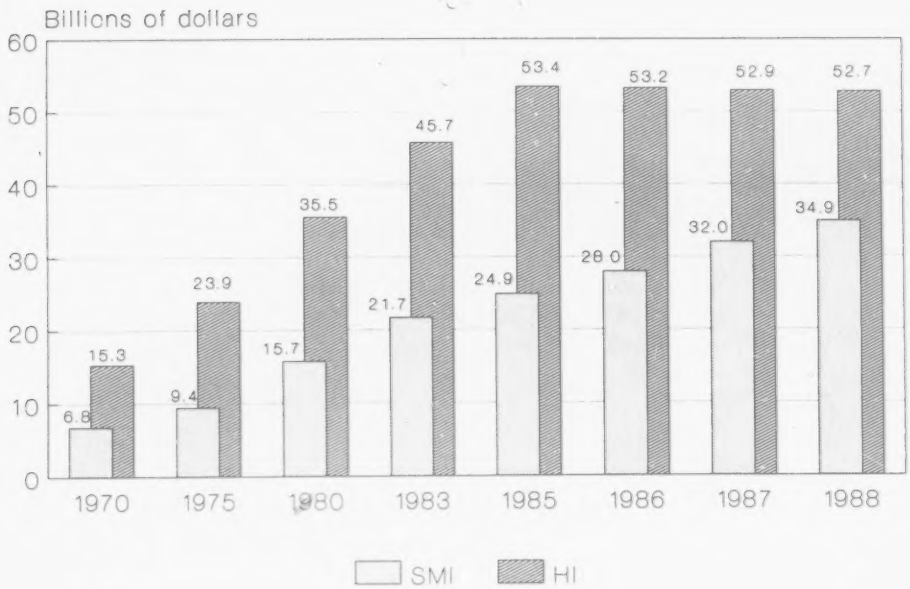
TABLE 12. Medicare: Comparing its Growth to Other Forms of Federal Spending, 1975-88

Fiscal year	Share of total Federal outlays				
	Medicare	Social security	Other human resource programs	National defense	Interest on debt
	(in percent)				
1975	3.9	19.5	28.7	26	7
1980	5.4	20.1	27.5	22.7	8.9
1988*	7.4	20.6	22.1	27.3	14.3

Source: U.S. Library of Congress. Congressional Research Service. *1990 Budget Perspectives: Federal Spending for the Human Resource Programs*. CRS Report for Congress No. 89-87 EPW, by Gene Falk and Keith Hurt. Washington, Feb. 2, 1989. Figures do not total to 100 percent.

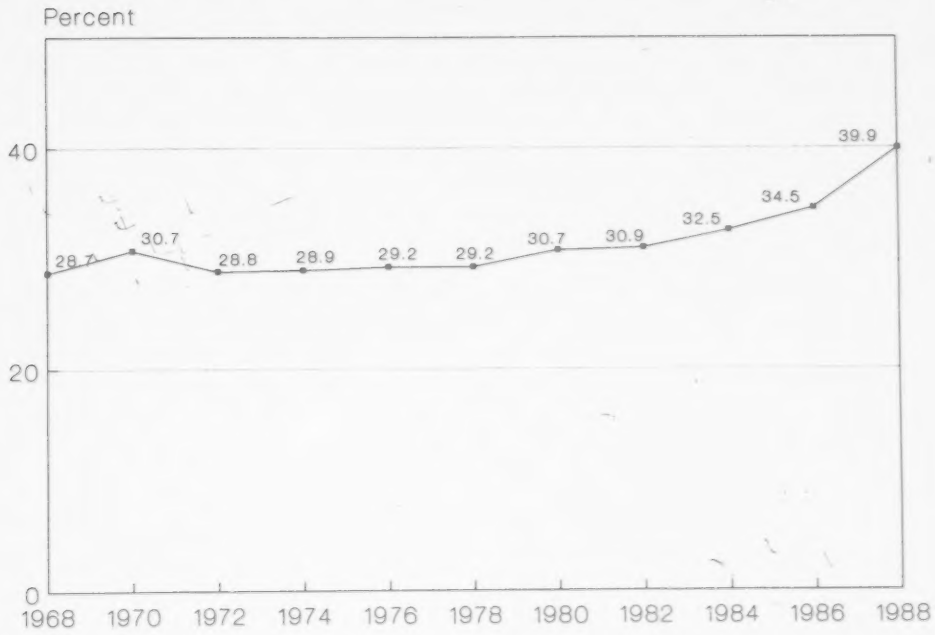
While HI's growth tended to slow in the 1980s, SMI's continued to surge. In 1967, SMI accounted for one-fourth of Medicare spending. By 1988, its share had grown to 40 percent. In the last 7 years, it grew three-fold, while HI doubled, and Federal spending overall only grew by 20 percent. Thus, SMI is likely to draw particular attention in the ongoing debate about the budget deficit and the appropriate level of Federal spending.

CHART 8. GROWTH OF HI AND SMI EXPENDITURES, FY 1970-88
(In 1988 constant dollars)



Source: Historical Tables, Budget of the U.S. Government.

CHART 9. SMI AS A PERCENT OF TOTAL MEDICARE EXPENDITURES, FY 1968-88



Source: Derived from Historical Tables, Budget of the U.S. Government.

How Medicare is Treated under Gramm-Rudman-Hollings

In 1985 Congress adopted special procedures to deal with the Federal budget deficits, which had grown from $74 billion in 1980 to $212 billion in 1985. The procedures, designed to bring the budget back into balance, have come to be known as the Gramm-Rudman-Hollings deficit-reduction law. Originally set to expire in FY 1991, the procedures were modified in 1987 and extended for 2 years, with the goal of bringing the budget into balance by FY 1993. Under the procedures a deficit estimate must be made prior to the beginning of each fiscal year. If the estimate exceeds the target by a certain defined margin, automatic spending reductions must be made by the President unless Congress intercedes and passes alternative deficit-reduction measures.[21]

In computing the estimated deficit, virtually all Federal income and outgo are counted under a so-called "unified" budget concept. Medicare's income and outgo are included (as are social security's). Thus, if the program's receipts are higher or lower than its expenditures, Medicare can affect the Gramm-Rudman-Hollings deficit figure and the amount of deficit reductions that may have to be implemented by the President or enacted by Congress. If the President must take action under the automatic procedures, Medicare reductions must be part of that action. However, the law limits the reduction, so that the so-called "sequester" order causes no more than 2 percent reduction in the projected benefit payout.[22]

In summary, under the current budgeting law Medicare directly affects the size of the overall Federal deficit, and benefit changes to constrain its spending may be part of the actions taken by the Administration or Congress to achieve certain prescribed budget goals.

How Medicare Affects the Deficits

People sometimes ask why, if Medicare is financed through trust funds, is it part of any budget discussions?

Since Medicare receipts and expenditures flow in and out of the general treasury, the difference between what the Government receives and spends for the program helps to shape the Government's overall financial condition.

There is no defined use of excess Medicare receipts, and there are no defined Federal resources earmarked to cover a Medicare shortfall. Excess HI taxes, for instance, are not used automatically to reduce the deficit. People

sometimes assume, ipso facto, that because excess HI receipts cause the Treasury Department to increase the securities posted to the HI trust fund, the Government "is simply borrowing money from the trust fund" rather than from financial markets. Since the amount the treasury borrows from financial markets represents the deficit, the immediate supposition is that excess HI taxes reduce the deficit.

However, while the law requires the Treasury Department to post securities to the HI trust fund when it receives HI taxes, it does not determine the ultimate use of the money. As with all other forms of Federal receipts, on a day-to-day basis the money is deposited in the treasury and pooled with other resources, and thereby helps to meet the Government's expenses as they arise. There is no way to track explicitly the flow of any Federal taxes from receipt to use. It can no more be said for HI taxes than for income taxes that they are used first to reduce government borrowing and then to meet spending obligations. The taxes become fungible once they reach the treasury. As the Government's bills come in, the monies in the treasury are used to pay them regardless of how the monies were raised or what the bills are for.

"Lower borrowing from the public" is only one of three possible uses that can be made of excess HI taxes. Ultimately, how excess taxes are used depends of fiscal policy decisions made by Congress and the Administration, not by the Treasury Department's day-to-day management of cash flow or accounting. To the extent policymakers are influenced to spend more or tax less because of the existence of one or more forms of excess taxes, then it could be said that the excess taxes haven't reduced the deficit. The basic point is that so long as excess HI taxes are part of the general operating pool of resources available to the Government, their use is determined by overall fiscal policy decisions.

By the same token a shortfall of HI receipts and the Government's contributions to SMI (the 75 percent share of SMI costs not covered by enrollee premiums) do not automatically cause the deficit to be higher. The Government may be making up the difference between Medicare receipts and expenditures with general resources, but this in turn could cause other spending to be lower or other taxes to be higher. Again, the impact is intertwined with aggregate fiscal policy decisions.

In summary, Medicare directly affects the Government's overall fiscal condition: how much it borrows, how much it spends, how much it taxes, and what the deficits are. However, there is no concrete way to determine exactly how, since it is difficult to ascertain how any one Federal program by itself influences the ultimate outcome of fiscal policy decisions.

[1]People reaching age 65 in 1994 or later will need 40 *quarters of coverage* to be eligible. DI recipients may become eligible with less than 40 *quarters* (depending on their age when the disabling conditions began), but they must have worked in covered employment fairly recently before their disabling conditions began. The 24-month waiting period does not apply to people with end-stage renal disease, but they are subject to a 3 month waiting period unless they are enrolled in a self-dialysis training program or scheduled for a kidney transplant.

[2]While the recent enactment of "catastrophic" coverage will increase the share of the program financed by premiums paid by enrollees, the vast share of the program's costs will continue to be financed through payroll taxes and general receipts of the Government. The Congressional Budget Office (CBO) estimates that premiums from enrollees will cover only 14.9 percent of aggregate Medicare payments in 1993 (i.e., after catastrophic protection becomes fully effective), in contrast to 10.3 percent today. See U.S. Congress. Congressional Budget Office. *The Medicare Catastrophic Coverage Act of 1988*. Staff working paper, Oct. 1988. p. 34.

[3]Physician Payment Review Commission. Annual Report to Congress. Washington, Mar. 1988. p. 22.

[4]Ibid.

[5]CBO estimates show that if the new catastrophic provisions had been fully effective in 1988, premium receipts would have represented 15 of overall Medicare income, instead of 9 percent.

[6]Under revised 1988 Trustees' report Intermediate II-B assumptions.

[7]People who attained age 72 before 1968 and who generally are not eligible under other provisions of the program because of little or no earnings credits.

[8]People receiving social security cash benefits are automatically enrolled in HI and SMI when their Medicare entitlement begins. They have to decline SMI coverage, if they do not want it. SMI is not voluntary for people who "buy into" HI (the "uninsured"); they must also enroll in SMI. People with end-stage renal disease who enroll in SMI must also take HI coverage.

[9]While SMI costs vary by type of enrollee--aged, disabled, and those suffering from end-stage renal disease--the premium rate is derived from the costs of the aged and is the same for all enrollees.

[10]This is the maximum potential premium when both members are eligible and file a joint return. However, where only one member of a couple that files a joint return is eligible for at least 6 months during the year, the maximum premium is limited to the amount that applies to single persons (e.g., $800 in 1989) and the premium is computed using only one-half of the couple's income tax liability. This does not apply to a member of a couple filing separate returns who must count all of his or her respective tax liabilities, and each is subject to a *couple's maximum*--$1,600 in 1989. If both are Medicare eligible, the potential maximum is $3,200 in 1989. Further, if they did not live apart the entire year, both are deemed to be Medicare eligible even if only one member is.

[11]The indexing procedures become effective in earlier years for Puerto Rico and the Commonwealths and territories.

[12]In effect, the expenditures are recorded against one trust fund and the corresponding premiums are credited to another, but no transfer is permitted between them. See conference report on the Medicare Catastrophic Coverage Act of 1988, p. 225.

[13]The information contained in this section was derived from three HCFA studies of national health spending; one reported through a press release on Nov. 18, 1988, and the other two reported in the summer 1987 and fall 1986 issues of the *Health Care Financing Review*.

[14]See National health expenditures, 1986-2000, loc. cit.

[15]See CBO, Oct. 1988, loc. cit.

[16]Dept. of HHS press release, Nov. 18, 1988, loc. cit.; and *1988 HI and SMI trustees'* reports.

[17]Derived from national health expenditure data; Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984, by Daniel R. Waldo and Helen C. Lazenby. *Health care financing review*. fall 1984; and *Income and resources of the population 65 and over*. SSA. Washington, U.S. Gov't. Print Off. SSA publication no. 13-11727. Using data from the Bureau of the Census' March 1985 Current Population Survey, SSA estimated the median money income of aged households with social security payments to be $10,260 in 1984. For aged households not receiving social security payments, the median was $8,020. HCFA estimated that Medicare financed $2,051 of the per capita health expenditures incurred by the population 65 and older in that year.

[18] Higher amounts apply to the self employed.

[19] U.S. Congressional Budget Office. *The Changing Distribution of Federal Taxes: 1975-1990*. Oct. 1987.

[20]The major human resource programs include social security, medicare, other health programs, veterans' benefits, education and social services, and other cash benefits, e.g., unemployment insurance and civil service retirement.

[21]The law requires the President to act, if the estimated deficit exceeds the Gramm-Rudman-Hollings target by more than $10 billion in FY89-92; if it exceeds zero in FY93.

[22]The reduction could be less than 2 percent, if the "uniform reduction" pertaining to non-defense spending is smaller.

OPENING STATEMENT

SENATOR DAVID PRYOR
Finance Committee, Subcommittee on Medicare and Long-Term Care

March 3, 1989

Hearing on the Medicare Program

Mr. Chairman, I would like to congratulate you on the scheduling of this hearing, the first of the new Subcommittee on Medicare and Long-Term Care and your first as Chairman. This subcommittee starts the 101st Congress with a full agenda, and I am pleased to have the opportunity to be a part of the challenging and difficult tasks that it has before it.

We are meeting today to discuss the current state of health care in this country. This hearing will give the members of this subcommittee some insight to the strengths and weaknesses of our health care delivery system, and further, give us some food for thought as we continue our efforts to find ways to meet the overwhelming current and future challenges facing the Medicare program.

As most of us know, the United States spends more for health care than any other country in the world. This fact is borne out by a quick review of some of the statistics that most likely will be presented today.

In 1987, Americans spent slightly over $500 billion, or 11.1 percent of the Gross National Product, on health care. That comes to about $1,987 for every man, woman, and child in this nation. In comparison, we spent $42 billion for health care in 1965, the year Medicare was enacted, which was about 6 percent of GNP, or $205 per person. And, if we don't find ways to effectively control our health care spending appetite, this trend cannot help but continue. In fact, HCFA has estimated that we will be spending 15 percent of our GNP on health care by the year 2000.

The amount of money spent out of the Medicare program alone is staggering. By itself, Medicare accounts for 27 percent of hospital spending and 22 percent of spending for physicians' services. While Medicare outlays for hospital care increased less than 2 percent in 1987, Medicare spending for physicians' services increased more than 10 percent. The Health Care Financing Administration projects that spending for physicians' services under Medicare will triple over the next ten years, without any expansion of the program.

Beneficiary spending on premiums has been increasing at an even more rapid rate. Over the past seven years, the deductible for hospital care has increased nearly 175 percent -- from $204 in 1981 to $560 in 1989. Last year alone, Medicare increased the monthly premium for its Part B coverage by an unprecedented amount -- 38.5 percent, from $17.90 in 1987 to $24.80 in 1988. The 1989 premium was increased again to $27.90; when the $4.00 monthly catastrophic premium is added to that, the $31.90 that Medicare beneficiaries must pay each month is more than ten times the monthly premium of $3.00 that they paid in 1966.

For the 7 1/2 million poor and near-poor elderly -- those whose annual incomes are below $8,000 -- these growing out-of-pocket costs represent an even greater problem. Not only do low-income elderly report poorer health status, but they also spend a higher proportion of their income on health care. And Medicaid, the health insurance program for the poor, is unavailable to the majority of poor

elderly. In 1984, only 36 percent of the non-institutionalized elderly poor were enrolled in Medicaid. Only 29 percent had private "medigap" insurance to supplement their Medicare benefits.

For nearly all older Americans, the Medicare program is the first line of defense when illness strikes. Prior to its enactment, about 44 percent of the elderly did not have any kind of hospital insurance. Medicare can also be credited -- at least in part -- with increasing life expectancy and decreasing death rates. Yet we are all aware of Medicare's shortcomings -- its ACUTE CARE, short-term focus, and its lack of coverage for such things as routine physicals, eyeglasses, hearing aides, and of course, long-term care.

While searching for solutions to the problems plaguing Medicare, it is vitally important that we not lose sight of caring for future generations of elderly. HCFA believes that our present generation of older persons will not dramatically affect growth in health care expenditures -- at least through the turn of the century. That will change when the baby-boomers begin to reach retirement age around the year 2010.

Although there are about 30 million Americans age 65 and over today, that number will increase to nearly 80 million by the year 2010. Compounding that problem is the fact that the rapid growth of the aged population in the next century likely will not be matched by growth in the working age population. What this means is that there will be proportionally fewer people working and paying taxes to help support medical care for growing numbers of elderly.

Escalating health care costs are among the biggest problems facing Americans of all ages. Senior citizens, though, are among the most vulnerable. They not only are living on fixed incomes, but they often use more health care services than the rest of the population. Those over age 65 are hospitalized twice as often as the younger population, stay 50 percent longer, and use twice as many prescription drugs. For many seniors, rising health care costs are a double-edged sword -- they use more services, but have less money to pay for them.

Although my focus as Chairman of the Special Committee on Aging is on the elderly, I know we face other, equally pressing problems with our health care system. As we approach the 20th century, we are faced with a health care system that leaves 35 to 50 million Americans out in the cold. One in five children is born in poverty, and our infant mortality rate ranks among the highest of all industrialized nations.

I firmly believe the United States has one of the best health care systems in the world. Yet despite our large investment in health care, there are far too many shortcomings. As the percentage of our GNP dedicated to health care continues to increase and at a time when we have limited resources to meet other high priority needs, me must look to ways to assure our health care system is yielding a product worthy of our tremendously expensive investment. Today's hearing will be a starting point for discussion of this tremendous challenge that we have before us -- how to control costs while ensuring access to quality care.

Again, I congratulate the Chairman for convening this hearing, and I look forward to the testimony of the expert witnesses that we have assembled before us today.

Opening Statement
Subcommittee Hearing on "Overview of Medicare"

John D. Rockefeller IV
March 3, 1989

Good morning, ladies and gentleman. We have gathered a truly impressive group of witnesses here today. I thank you for coming, and I look forward to hearing your testimony this morning.

This, as most of you know, is the very first hearing of the Subcommittee on Medicare and Long-Term Care. And as its first Chairman, I am genuinely honored to have this privilege. With Senator Durenberger, a true champion of the Medicare program and the goal of quality health care for all Americans, I am sure that the subcommittee will have a productive, compelling two years.

This new subcommittee is responsible for watching over one of the most important federal programs in the nation, and for addressing issues that are complex and affect the well-being of millions of Americans. I know that the goal of all of the dedicated members on the subcommittee is to provide a forum where solutions to problems are searched for, and a process in which all sides will be heard.

It is fitting, I believe, to launch our work in the 101st Congress with a hearing devoted to taking a "big-picture" look at Medicare. Today, we will ask: How is Medicare working? Has it adapted to the demands of today's elderly and disabled population? What can we do about the trend of Medicare spending? Are there ways to contain costs safely? How do we make sure the elderly receive the care they need, when they need it, and in the appropriate setting? What are the key issues to consider in trying to bring about long-term care coverage?

Congress made a historic commitment to the elderly when it passed the Social Security Act in the 1930's. With the passage of the Medicare program in the mid 60's, this commitment was reaffirmed. Most people would agree that the Social Security program combined with the Medicare program work together to protect the nation's elderly financially and makes sure they receive essential medical care. There is no doubt that the elderly are better off today than a generation ago.

I want us to think big today. I even want to hear what is good about the Medicare program and be reminded of what must be preserved. I encourage you to express your vision of larger reforms or restructuring that you believe we should ponder -- even include your "wilder" or more provocative thoughts.

I also invite you to help us consider what we can realistically do to respond to the needs of beneficiaries when we still are faced with a huge federal deficit. What needs immediate attention? What specific issues should this committee

be focusing on this year and next year? Your knowledge and recommendations will help us set legislative priorities.

As the witnesses know, most members of Congress are keenly interested in health care and the Medicare program specifically. The lack of long-term care coverage, and the size of the uninsured population, are facts. We may react differently to specific proposals and recommendations. But we seem to all share a desire to improve the quality of health care for our citizens, ensure the best possible access to health care, and to see providers compensated fairly and adequately for their services.

We have invited you to this hearing to help us embark on our effort to consider these issues and many more in the 101st Congress. This should be an interesting and useful morning. Again, I thank the witnesses and look forward to tapping your vast knowledge today and hereafter.

OPENING STATEMENT OF SENATOR JOHN HEINZ

FINANCE Subcommittee ON MEDICARE AND LONG TERM CARE

Overview Hearing on the Medicare Program

March 3, 1989

Allow me to commend you, Mr. Chairman, for convening this first hearing of the Subcommittee to take a critical look at the Medicare program which is in rapidly failing health.

For nearly a decade, the Congress has attempted to rein-in escalating health care costs and to contribute to deficit reduction by constraining growth in Medicare spending. We did this in ways we believed were equitable and would ensure the beneficiary's continued access to high quality care. We are now seeing the returns on our sustained cost containment efforts -- and they are mixed.

Legislative reforms in hospital, physician and other provider payments since 1982 have provided nearly $13 billion in Medicare savings and deficit reduction. These savings have come, however, with a price. The price of the change in hospital payment to prospective reimbursement was that patients were pushed out the back door. Now, patients can't get in the front door -- as hospitals, especially in rural areas, are finding it harder to stay in business. Over 150 hospitals have closed since prospective payment went into effect. Of these, 81 closed just last year; including two from my own state. Another 600 hospitals may go into bankruptcy if financial constraints

are not eased. In Pennslyvania, preliminary survey findings are also showing that at least 31 percent of our hospitals are experiencing net operating losses.

The price of cost containment under Medicare's Part B side is quite different. Despite or because of price controls on physician and other Part B services, total expenditures have continued to rise by 16 percent annually -- driven largely by increases in the volume of services performed. This has added to Medicare's program costs, has stretched the beneficiary's out-of-pocket liability, and most importantly, may be subjecting patients to more, potentially unnecessary or risky tests and procedures. I believe we need to be especially sensitive to the increasing cost of Medicare for the beneficiary. In the last two years alone, the beneficiary's Part B premium increased 56 percent, from $17.90 to $27.90 a month. That's before the $4.00 catastrophic premium is added to the equation.

This is the environment in the President is asking for another $5 billion in Medicare cuts. Whether we are looking at $5 billion or something below that figure, we face difficult budgetary decisions this year that are of great consequence to beneficiaries in the near and long-term. I am therefore pleased, Mr. Chairman, to see the panel of experts before us today. I welcome this opportunity to learn their views on how we should proceed in building an affordable and equitable system of care that does not jeopardize, and as needed, will restore health care access and quality.

MEDICARE PART B EXPENDITURES: OUT OF CONTROL?

Karen Davis

Thank you, Mr. Chairman for this opportunity to testify on the present problems and challenges facing Part B of the Medicare program. Attention to this part of Medicare is long overdue. While Congressional action in recent years has been at least partially successful in slowing hospital expenditures under Medicare, expenditures for physician and other ambulatory services under Medicare have continued to spiral upward.

Today, I would like to review the experience with Part B expenditures and the sources of rising costs. The difficulties rising cost of physician services pose for the elderly are then reviewed. Finally, I would like to share with the Committee some thoughts on possible approaches to curbing these unsustainable expenditure trends while protecting elderly and disabled beneficiaries from the brunt of rising costs.

Medicare Part B

Part B, the Supplementary Medical Insurance (SMI) program, covers the costs of physician services and such additional benefits as outpatient laboratory tests, durable medical equipment, and outpatient hospital care. Unlike Part A which is largely financed by Social Security payroll taxes, Part B is optional for enrollees and is financed by a combination of general revenues and beneficiary premiums. Increases in Part B outlays are a major drain on general tax revenues and a contributing factor to the overall federal budget deficit.

Rising premiums are a direct financial burden on the elderly and disabled beneficiaries. While coverage is voluntary, an estimated 97 percent of Part A beneficiaries choose to enroll in Part B as well. In recent years, beneficiary premiums have covered 25 percent of Part B costs. The monthly premium for Part B enrollees in 1988 was $24.80, or $298 a year, up from $36 a year in 1966, and 38.5 percent higher than the 1987 premium. In addition, Medicare beneficiaries pay a $75

deductible for Part B services and are responsible for 20 percent coinsurance on allowable charges. Unlike hospitals, physicians are permitted to charge patients in excess of charges allowed by Medicare. Therefore, some beneficiaries find themselves with quite substantial out-of-pocket outlays for physician services. The recent Medicare Catastrophic Coverage Act sets a ceiling on the deductible and coinsurance expenditures for Part B, but does not restrict excess billing by physicians.

Trends in Part B Expenditures

Total Medicare outlays have been increasing rapidly, about 15 percent per year between 1975 and 1988 -- reaching a total of nearly $88 billion in fiscal year 1988. This represented about 8 percent of the entire federal budget.

The fastest growing portion of Medicare is Part B which accounts for about 40 percent total Medicare spending, approaching $35 billion in fiscal year 1988. Physican services accounted for $24 billion--about two-thirds of all Part B outlays. Part B expenditures increased about 18 percent a year between 1975 and 1988. Even without any program expansions, Medicare spending for physicians' services is expected to triple over the next ten years.

Increases for physician expenditures far exceeded those of hospital expenditures in recent years. The real rate of increase in hospital benefit payments has slowed markedly since the introduction of a new system of paying hospitals under Medicare introduced in 1983. Between 1984 and 1988 hospital expenditures increased at a real annual rate of about 6 percent, down from over 15 percent in the period from 1980 to 1983.

By contrast, the real rate of growth for physician expenditures has slowed only slightly and remains quite high -- from about 18 percent annually from 1980 to 1983 to a real annual increase of about 14 percent from 1984 to 1988.

In upcoming years, the Congressional Budget Office predicts that Medicare outlays will continue to grow at an unacceptably high rate. From 1988-1994, Part A expenditures will increase at an average annual

rate of 10.4 percent. Expenditures for physician services will grow even faster, averaging 12.8 percent per year. Over the same time period, expenditures for total Part B services will more than double, growing by 15 percent a year. By 1994, Part B alone will cost over $80 billion a year, nearly what all of Medicare costs today.

The spiralling costs of Part B are largely attributable to three components, that is, increases in volume and intensity of services per enrollee (accounting for 44 percent of increased costs), price increases (accounting for 42 percent of increased costs), and increases in enrollment (accounting for 14 percent of increased costs).

Increases in volume and intensity of services may be due in part to the use of new technologies in diagnosis and treatment, and the recent shift in some surgery from inpatient to outpatient settings. Part B services per enrollee grew steadily between 1975 and 1985 at more than 7 percent per year.

Additionally, the types of services provided have changed in recent years, with diagnostic tests and supplies and equipment experiencing very rapid growth. Together these categories constituted 31 percent of Part B approved charges in 1987, up from 20 percent in 1975. This has caused a relative decline in the percentage of Medicare Part B payments going toward medical services.

Price increases have also contributed substantially to the growth in Part B outlays. Between 1980 and 1985, approved charges for office based surgery increased by nearly 12 percent a year and for medicine by 5 percent per year. Legislative efforts temporarily freezing physician fees probably helped to slow price increases somewhat, but the effect may have been offset in part by volume increases during the same time period.

Increases in enrollment in Medicare have contributed to increasing costs to a lesser degree. However, over the next several decades, the number of elderly persons enrolled in Medicare will grow substantially, and will be a major reason for increased federal outlays. Those age 65 and older currently account for about 12 percent of the population. That figure will grow to 13 percent by 2000 and then increase rapidly

to 22 percent by 2050, when Medicare will have more than 65 million beneficiaries. Furthermore, the aged group is itself aging, with the fastest growth occurring among those age 85 and older. This has significant consequences for the Medicare program, as frailty and use of health services increase with age.

Financial Burden on Beneficiaries

In recent years, concern over rising health expenditures has caused many to doubt Medicare's ability to provide adequate financial protection to our elderly people. Overall, Medicare covers 58 percent of expenditures for use of physicians services by the elderly (this includes Medicare expenditures financed by beneficiary Part B premium). Private insurance pays for about 13 percent, and Medicaid contributes only 2 percent. Direct out-of-pocket payments by beneficiaries account for one-fourth of all physician expenditures.

Beneficiaries' out-of-pocket liability for acute care services comes from coinsurance and deductibles for Part A and B, amounts billed in excess of approved charges, premiums for Part B, private Medigap premiums, and charges for uncovered services. Based on a study by the Select Committee on Aging, beneficiaries are responsible for an average of $2,394 per elderly person in 1988. In 1988 the elderly spent just over 18 percent of their limited incomes on health care expenses, up from 12 percent in 1977.

The combined effect of increasing premiums, cost-sharing requirements, and extra billing for Part B is substantial. Such costs have tripled for elderly enrollees between 1975 and 1987.

On the average, the incomes of elderly Americans have risen significantly since the inception of Medicare. The poverty rate for the elderly has declined from more than 29 percent in 1967 to 12 percent in 1987. Still, more than 3 million elderly have incomes below the poverty line, that is, below about $5,700 for a single elderly person in 1988. Another four and one half million, or 16 percent, have incomes between 149 percent and 100 percent of the poverty line. As many as a third of the near-poor elderly would be considered impoverished if their out-of-pocket medical expenses were deducted from their available income.

Because of the cost-sharing requirements associated with Parts A and B of Medicare, the majority of elderly people now have supplementary insurance coverage. Seventy one percent of the elderly purchase private Medigap policies, and another 9 percent are covered by Medicaid. However, fully 20 percent of the elderly in 1986 had no supplementary protection for expenses not covered by Medicare.

The recent Medicare catastrophic law provides for mandatory coverage of all poor Medicare beneficiaries under Medicaid. For these beneficiaries Medicaid will pay Medicare premiums and cost-sharing. The Health Care Financing Administration has proposed regulations that would permit physicians to bill these patients in excess of Medicare allowed charges. Further, the new law does not expand Medicaid coverage for the near-poor elderly, many of whom will continue to face serious financial burdens.

Physician Participation and Assignment

The primary goal of the Medicare program is to offer beneficiaries access to quality medical care while providing financial protection from high health care costs. One of the most serious threats to this goal is billing in excess of assigned charges, or "balance billing." Although many physicians choose whether or not to accept assignment on a case by case basis, a significant number have joined the participating physicians' program (PAR) which was instituted in 1983. Physicians in the PAR program sign an agreement to accept assignment on all bills for Medicare patients. Physicians who sign participation agreements offer beneficiaries the certainty of obtaining services on an assigned basis, an assurance which is often not otherwise available.

In 1988, over 37% of physicians signed participation agreements accounting for 58% of physician charges. This is a significant increase from previous years where only 30% or less participated.

Assignment rates for Part B services were relatively stable during the mid-1970s at just under 50 percent, then began to rise gradually, reaching 56.5 percent in 1983. With the inception of the participating physician program (PAR), assignment rates have increased dramatically by over 20 percentage points to nearly 79% of charges accepted on

assignment in 1988. In part this could reflect limits on charges of nonparticipating physicians (so-called MAAC limits) and the favorable differential in allowed prevailing charges for participating physicians. Other reasons for the increase in assignment include required assignment for laboratory claims which went into effect in 1984, and probably, increased competition resulting from continuing increases in physician supply. Additionally, there is evidence that nonparticipating physicians are taking assignment more frequently in recent years.

While the increases in participation and assignment rates represent good news to many beneficiaries, others still face significant out-of-pocket expenditures from balance billing. Between 1976 and 1986 the percentage difference between the actual charge and the Medicare approved charge of unassigned Part B claims increased from less than 20 percent to nearly 27 percent. However, the implementation of maximum allowable actual charges (MAACs), appears to have substantially limited the size of extra bills in 1987. This reduction, coupled with rising assignment, resulted in an estimated drop in beneficiary liability for extra billing from $2.9 billion in 1986 to $2.5 billion in 1987. Preliminary evidence suggests, however, that many low income and sick beneficiaries continue to face burdensome excess bills.

Despite rising assignment rates overall, there exist significant variations among geographic regions and specialties. These variations in assignment rates are quite large and have major ramifications for beneficiaries. The likelihood of obtaining care on an assigned basis depends significantly on where the beneficiary lives and the types of services needed.

Among the 50 states, physician assignment rates have been found to vary from 24 percent to 95 percent. Generally, the highest assignment rates occur in the Northeast, the lowest in the North Central region and the South.

Assignment rates also show large variation among specialties. In 1985, assignment rates ranged from a low of 51 percent for

anesthesiology to a high of 81 percent for psychiatry. Primary care specialties have lower assignment rates than medical subspecialties. In surgery, however, general surgery has a somewhat higher assignment rate than most surgical subspecialties.

Possible Changes in Medicare Physician Payment

The problems I have outlined here today make Part B of the Medicare program a priority target for reform. Any reform policies implemented must be aimed at achieving multiple, and often conflicting goals, such as reducing the growth of Part B outlays, ensuring access to quality care, protecting the financial security of beneficiaries, and promoting equity in payment to physicians. There are several options, or combination of options, which merit consideration in this context for reform. In general, these options include a fee schedule, expenditure targets, and mandatory assignment or limits on physician balance billing.

The current method of paying physicians by the lowest of customary, prevailing or reasonable charges is inherently inflationary, inequitable among physicians, and inordinately complex and difficult to understand and manage. The implementation of a fee schedule would greatly simplify the program. The relative values of the fees should be based on the resource costs of providing each service.

Although a fee schedule will place control on the price of physician services, this mechanism may be of limited effectiveness in moderating increasing Part B expenditures unless it is coupled with a method which focuses on the volume of services provided. Expenditure targets constitute one way of providing incentives to physicians to curtail volume of services. Under this system annual increases in physicians' fees are based on how total physician expenditures in the previous year compare with trends in the overall economy or federal budget. If physicians collectively control the volume of services, they would be rewarded with higher fees in the following year. Expenditure targets could supplement other measures designed to reduce services of little or no benefit to patients. The intent of expenditure targets is to make clear to the physician community their

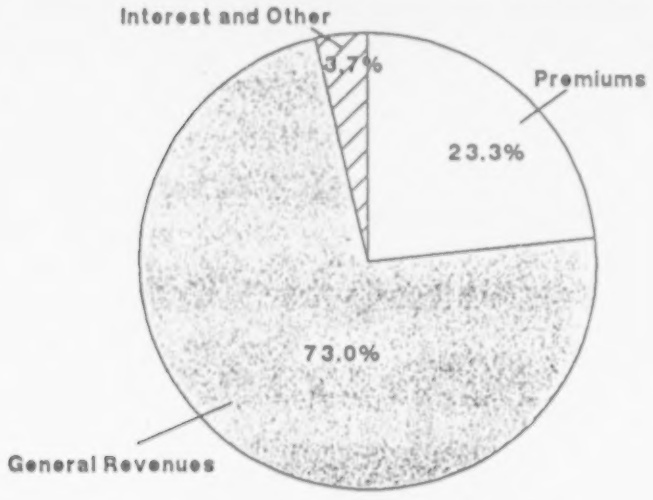
responsibility to employ medical resources wisely, and to support utilization review methods and development of appropriateness guidelines to moderate the rate of expenditure growth.

In order to reduce the out-of-pocket expenses of beneficiaries, it is necessary to limit the amount of balance billing by physicians. Mandatory assignment, or a limit on the percentage physicians are allowed to bill in excess of the Medicare fee schedule, are two options for controlling beneficiaries' financial liability.

It is clear that to achieve the multiple goals of the Medicare program, an integrated strategy for reform, which encompasses such options as presented here today, is necessary. Restricting the growth in Part B expenditures through a unified, comprehensive physician payment policy would have a major impact on the future trends in health expenditures, Medicare outlays, the federal budget, the financial security of our elderly population, and access to quality health care.

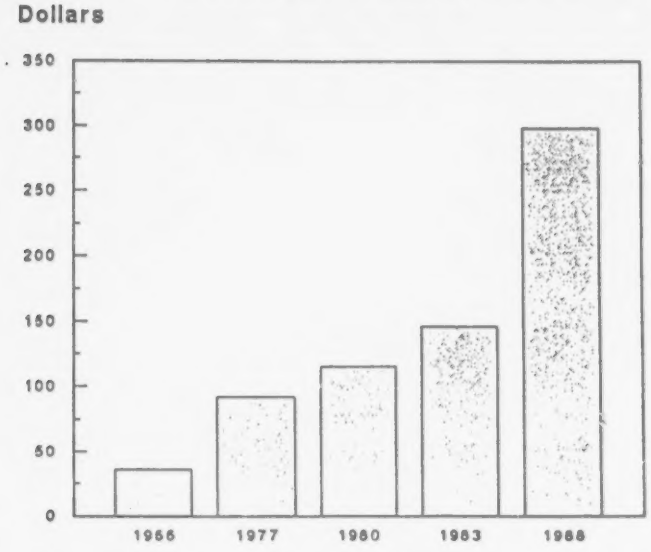
Thank you.

Figure 1. Supplementary Medical Insurance Trust Fund Revenues in FY 1987



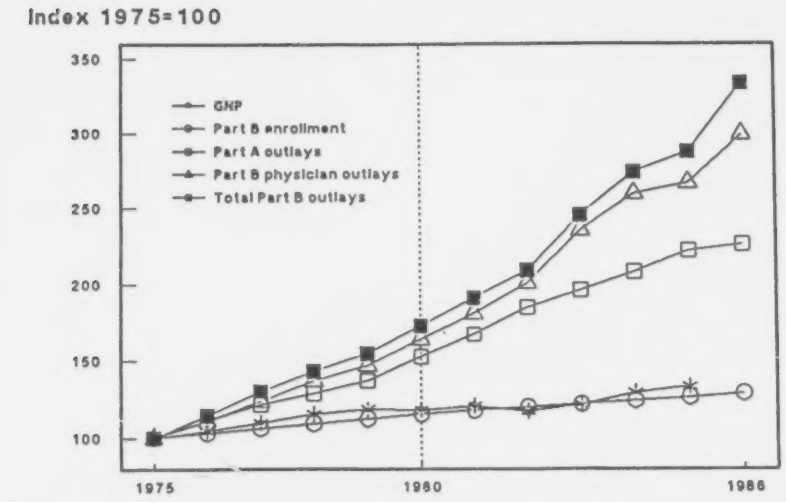
Source: U.S. Department of the Treasury.

Figure 2. Medicare Part B Annual Premium, Selected Years, 1966-88



Source: Health Care Financing Administration.

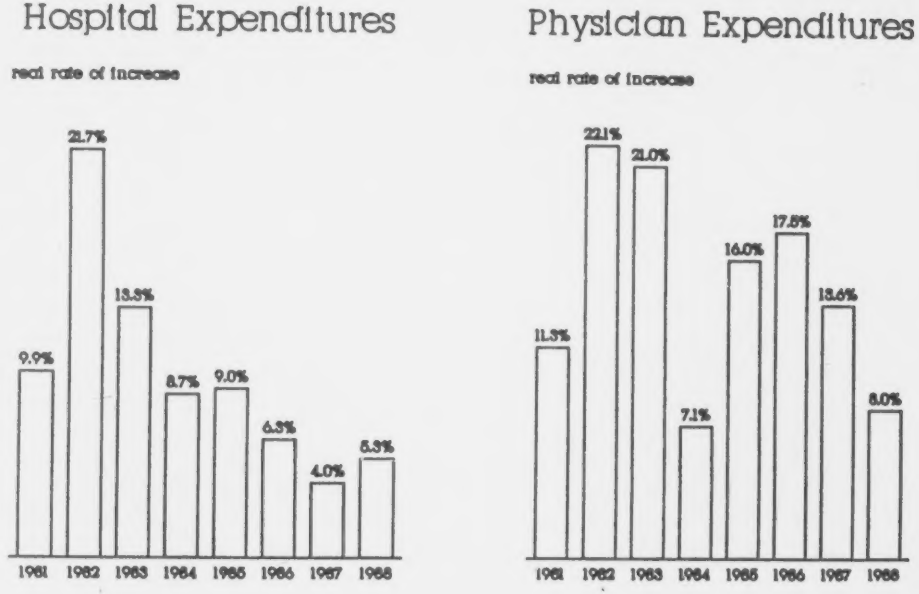
Figure 3. Trends in Real Medicare Expenditures, 1975-86



Sources: U.S. Department of Commerce and Health Care Financing Administration.

Figure 4

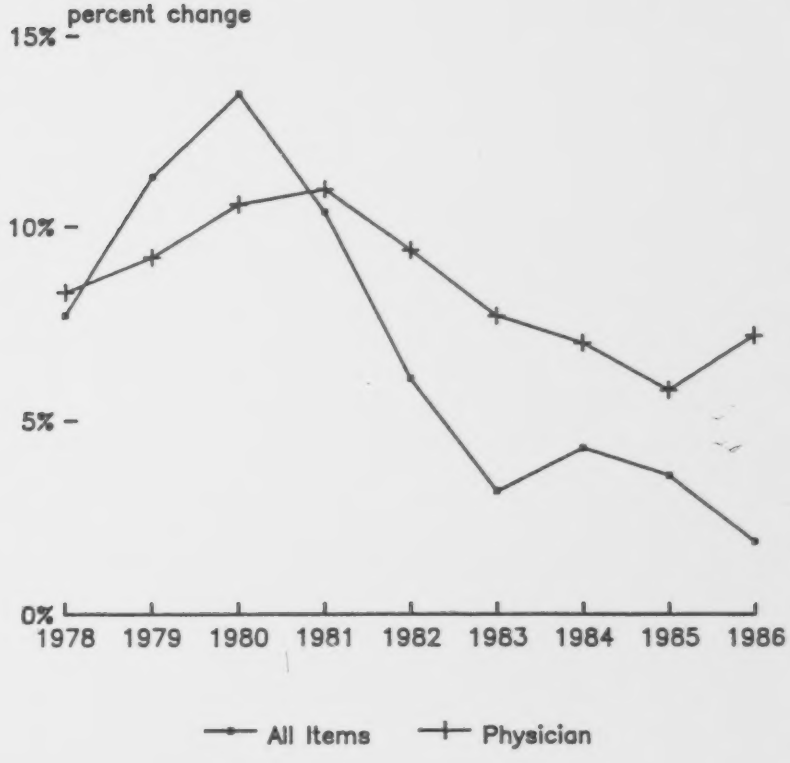
Real Rates of Increase in Hospital and Physician Expenditures by Medicare, 1980-1988



Source: JHU estimates based on HCFA Review Spring 1986, Summer 1987 and HCFA data released November 1988.

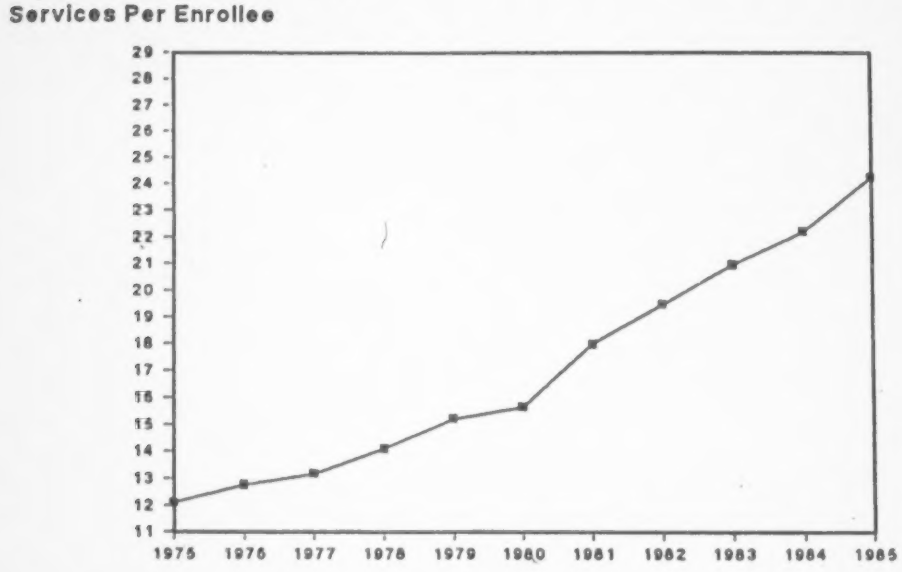
Figure 5

Annual Percent Change in the Consumer Price Index for All Items and for Physician Services, 1978–1986



Source: Statistical Abstract of the United States, 1987 and HCFA Review, Summer 1987.

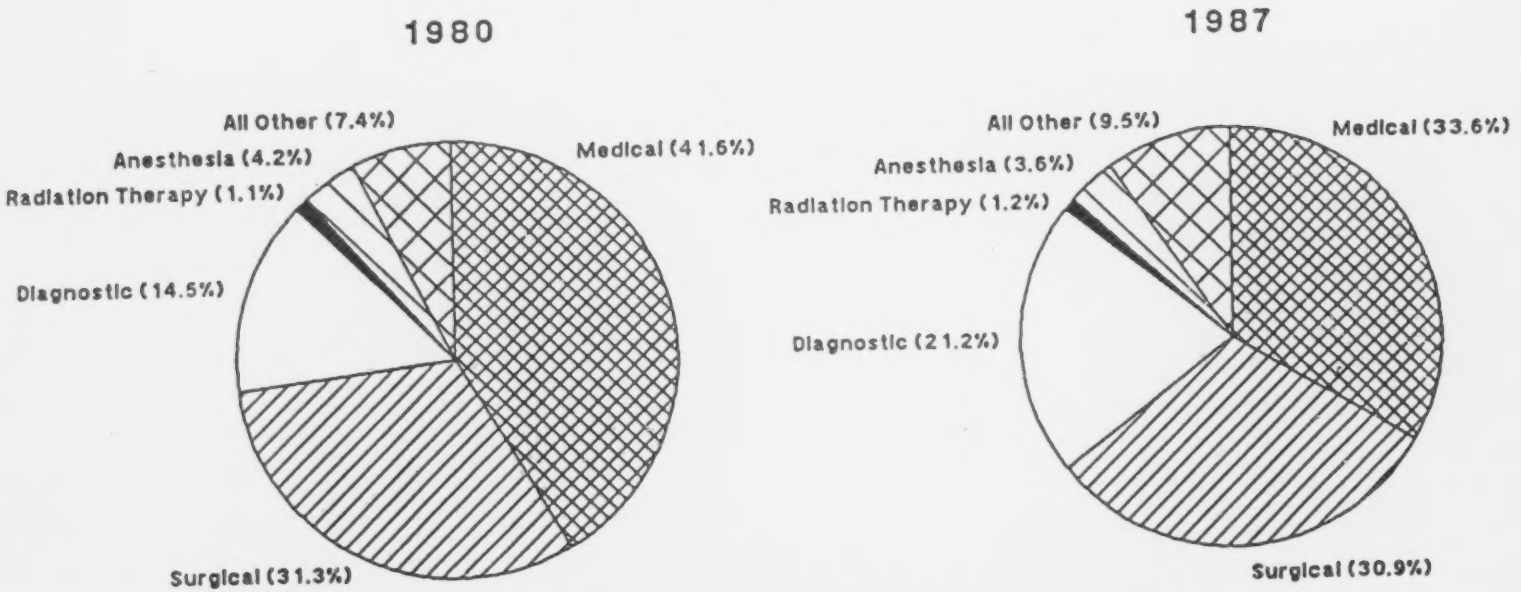
Figure 6. Total Part B Services per Enrollee, 1975-85[a]



Source: Health Care Financing Administration, Medicare Part B Summary Data.

[a] Services are gross counts of approved billed services.

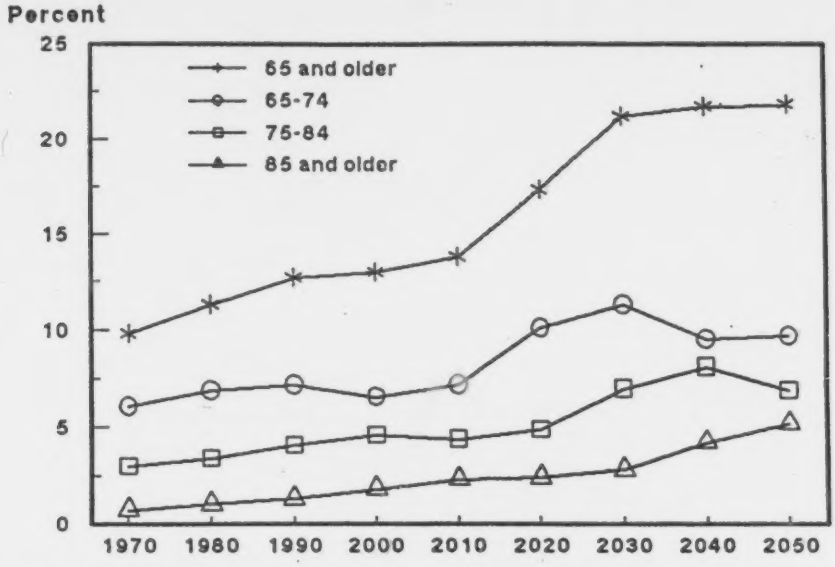
Figure 7. Distribution of Part B Allowed Charges by Type of Service, 1980 and 1987[a]



Source: Health Care Financing Administration, Medicare Part B Bill Summary Data.

[a] The category "All Other" is primarily composed of equipment, supplies, ambulance service, and durable medical equipment.

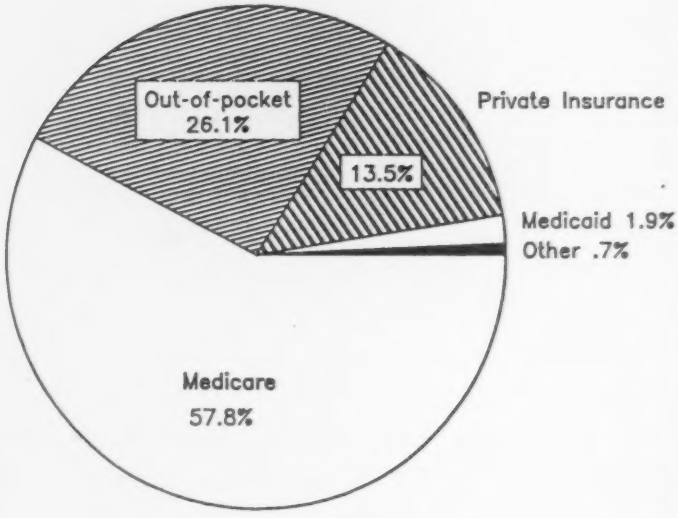
Figure 8. Elderly People as a Proportion of Total Population, 1970 projected to 2050



Source: U.S. Special Committee on Aging, American Assocation of Retired Persons, Federal Council on Aging, and U.S. Administration on Aging.

Figure 9

Sources of Payment of Physician Expenditures by the Elderly, 1984

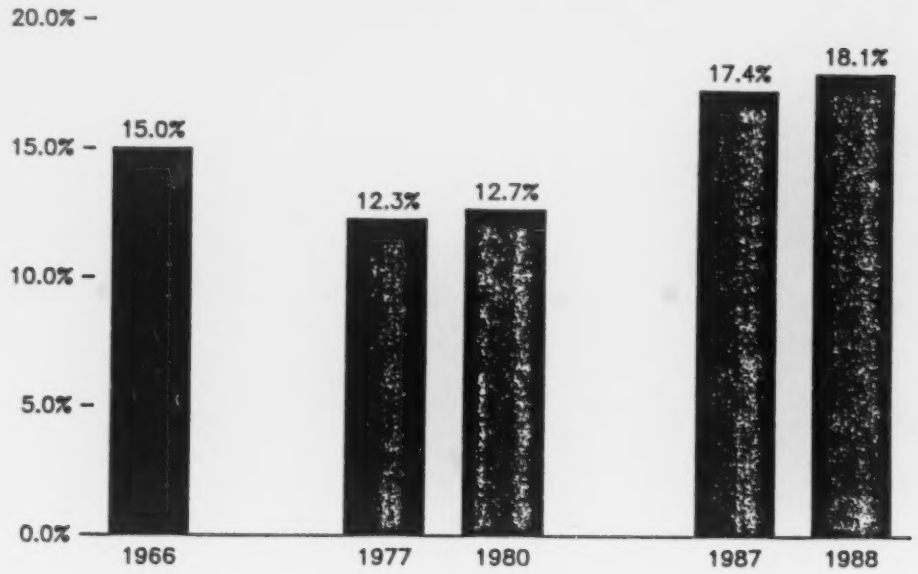


Physician Services by Elderly

Source: Waldo and Lazenby, 1984.

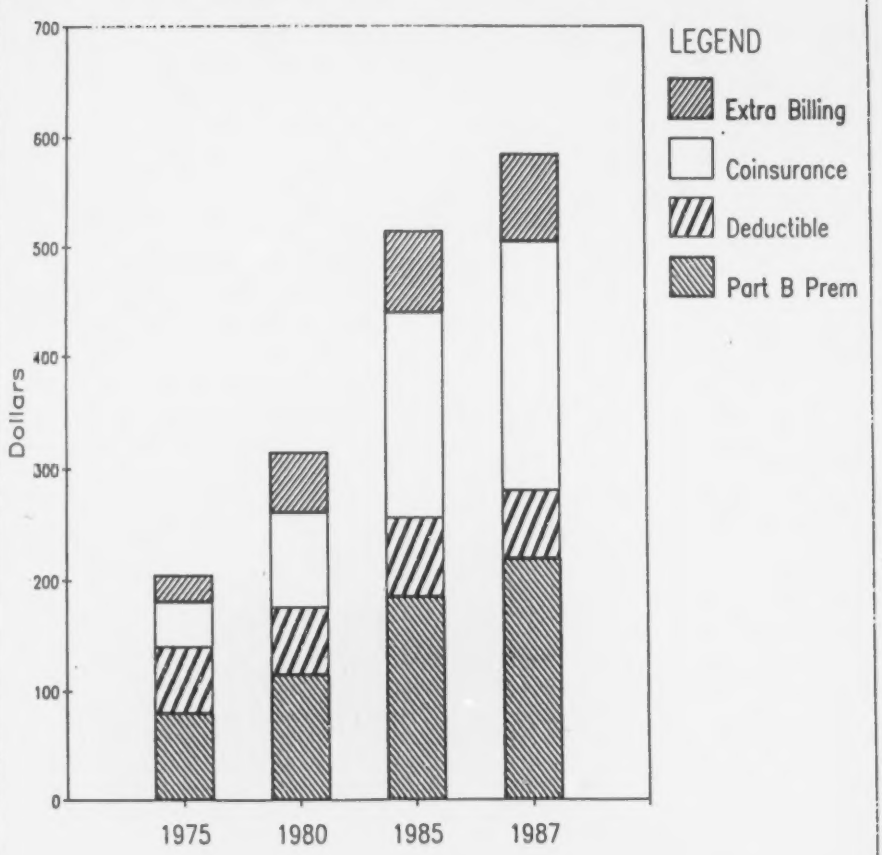
Figure 10

Elderly Out-of-Pocket Health Costs Percentage of Income (1966-1988)



Source: Edward R. Roybal. Chairman. U.S. House of Representatives Select Committee on Aging. October 26, 1988

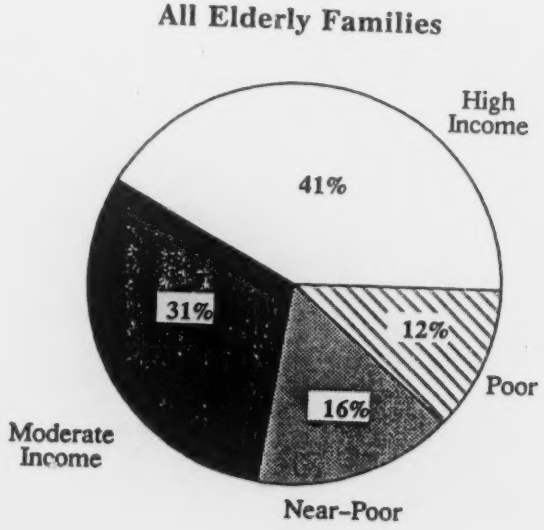
Figure 11. Average Annual Estimated Out-of-pocket Costs per Aged Enrollee for Covered Part B Services, Selected Years, 1975-87



Source: Office of the Actuary and Div. of National Cost Estimates, Health Care Financing Administration

Percentage of Poor, Near-Poor and Non-Poor Elderly Families 1987

Figure 12



Source: Old, Alone and Poor, 1987

Figure 13.

The Impact of The Participating Physician Program, 1984-1987 (in percent)

PAR Period	Physicians Signing PAR Agreements	Covered Charges
October 1984 - September 1985	30.4	36.0
October 1985 - April 1986	28.4	36.3
April 1986 - December 1986	28.3	38.7
January 1987 - January 1988	30.6	47.1
April 1988 - January 1989	37.3	58.2 (3rd qtr. only)

Sources: HCFA, Medicare Participating Physician/Supplier Claims Workloads Reports and unpublished data from HCFA, Bureau of Program Operations.

Note: Covered charges are PAR physicians' covered charges as a percent of total covered charges for physicians' services.

Figure 14.

Assignment Rates and Charge Reduction Rates for Total Part B Services, 1973-1987 (in percent)

Calendar Year	Assignment Rate		Charge Reduction Rate	
	Claims	Charges	All Claims	Unassigned Claims
1973	56.9	49.7	12.2	12.6
1974	56.0	49.1	14.4	14.7
1975	55.9	49.0	17.4	17.7
1976	54.4	48.9	19.5	19.8
1977	54.0	49.6	19.0	19.0
1978	53.7	50.9	19.3	19.2
1979	54.0	51.9	20.8	20.7
1980	54.2	52.9	22.4	22.5
1981	54.9	54.2	23.5	23.8
1982	54.4	55.4	23.7	23.9
1983	55.8	56.5	23.2	23.0
1984	59.2	59.7	24.9	24.2
1985	68.5	68.6	26.9	25.9
1986	68.0	69.6	27.9	26.9
1987	73.3	75.2	27.2	24.7
1988 (3rd qtr.)	75.2	78.9	29.3	25.5

Sources: HCFA, Medicare Participating Physician/Supplier Claims Workloads Reports and Reasonable Charge and Denial Reports

FIGURE 15. Beneficiary Liability for Excess Billing on Unassigned Claims, for Total Part B Services, 1979-87

Calendar Year	Total Liability (in $ billions)
1979	1.16
1980	1.54
1981	1.88
1982	2.28
1983	2.51
1984	2.72
1985	2.60
1986	2.89
1987*	2.54

*preliminary

Source: PPRC, Annual Report to Congress, March 1988.

Figure 16. Physician Assignment, Participation, and Charge Reduction Rates by Specialty (in percent)

Specialty	Assignment Rate 1985	Participation Rate 1987	Charge Reduction Rate 1983
Anesthesiology	51	20	38
Cardiology	67	43	23
Family Practice	60	27	24
Gastroenterology	74	n/a	20
Internal Medicine	62	34	23
Neurology	67	37	28
Opthalmology	65	35	21
Orthopedic Surgery	55	33	27
Psychiatry	81	29	32
Radiology	69	40	22

Source: PPRC, Annual Report to Congress, March 1988.

MEDICARE ADMINISTRATION

Testimony
by

Lynn Etheredge

Mr. Chairman and Members of the Committee:

I appreciate the invitation to testify before you today about administration of the Medicare program.

My professional work with the Medicare program's administrative issues includes serving as director of OMB's professional health staff from 1978-1982 and, previously, as its lead analyst for health care financing programs. In the last few years, my work has also included studies of Medicare's benefits, financing and payment policies and the financing and management of long term care services. I am appearing today as an independent witness.

Over the next five years, the Medicare program faces the greatest administrative challenges since its enactment. Among these major management issues will be implementation of the catastrophic insurance legislation (particularly the prescription drug benefit), dealing with the rising volume of physicians' services, potential transition to a new physician payment system, the evolution of the DRG hospital payments, building the administrative foundations needed for expanded long term care insurance benefits, and development of its internal management capabilities.

This statement includes a brief overview and history of the Medicare program's administration. But I will focus primarily on

these management challenges, since they may well constitute major issues for Congressional concern over the next five years.

Medicare's Administrative Structure

The Medicare program's administrative structure stands out from most federal government management arrangements in two major respects.

First, the Medicare program's scale and complexity make it one of the federal government's most formidable administrative responsibilities -- now and for the next half century. Medicare's spending -- about $120 billion in 1990 -- is second, among domestic programs, only to social security. In making its payment determinations, Medicare reviews and pays bills for about 1 billion services annually. Its payment policy complexities reflect its role as the major financer of the rapidly-growing U.S. health sector which, with $500 billion of income in 1987, itself would already rank as the eighth largest of the world's economies. In terms of impact on citizens, Medicare serves more than 32 million beneficiaries and pays over half of the medical care bills of the nation's elderly population. Over the next ten years alone, current projections show cumulative Medicare spending will be more than $1.8 trillion -- and its spending will continue to grow, with retirement of the baby boom generation, at least to 2050 and beyond.

Second, the Medicare program's administrative structure for carrying out these responsibilities reflects a unique set of government-private sector arrangements. These arrangements are extraordinary in the degree of administrative delegation -- and discretion -- accorded to private sector agents. These agents, rather than federal employees, perform virtually all of the day-to-day

Medicare program operations, including paying bills, auditing cost reports, reviewing medical appropriateness of care, surveying nursing homes, and communicating with beneficiaries and health care providers. The extent to which these administrative roles are directed in statute, and the legal limits on Medicare's authority to select and manage its contractors, are also unique to the Medicare program.

Let me describe the major actors in more detail.

--HHS's Health Care Financing Administration (HCFA) has the lead government responsibility for Medicare program administration. Most of HCFA's Medicare staff work on central office functions such as policy setting, managerial oversight of contractors, maintenance of master beneficiary records, actuarial and data analyses, research and other core functions.

--Medicare hospital insurance (HI or Part A) program is managed by *fiscal intermediaries* which audit hospitals' cost reports and make payments under the DRG system. Most intermediaries are state-level Blue Cross plans that been with the Medicare program since its inception. They became Medicare's designated fiscal agents by being nominated for this role by hospitals which, under the Medicare statute, have the right to nominate the contractors that will review their claims and audit their cost reports.

--*Professional Review Organizations (PROs)*, which are typically physician-sponsored organizations, primarily review the medical appropriateness of hospital admissions. PROs were not part of the original Medicare structure but are a result of 1972 amendments that transferred the hospital quality and utilization review functions

from intermediaries to newly created local-area agencies, the Professional Standards Review Organizations (PSROs). The Medicare amendments of 1982 re-organized the PSRO functions into state-level PROs.

--Medicare supplemental medical insurance (SMI or Part B) is administered by *carriers*. By requirements of the Medicare statute, Medicare must contract with private insurance companies to perform these functions. Both Blue Shield plans and commercial insurance companies play major roles. Here again, state-level contractors are most common. These carriers carry on the complex determinations of Medicare's payment rates under the CPR system, as well as medical review functions for physicians and other outpatient services.

--*State agencies* carry on survey and certification of nursing homes and some other providers to assure they meet federal standards.

These arrangements have both political and practical histories. Politically, when Medicare was enacted, fears of government regulation were major worries for health care providers. The hospital nomination process and reservation of administrative roles for private insurance companies helped to assure that these contractors would serve as buffers between government and health care providers and that Medicare would follow private sector practices. These arrangements also helped to protect beneficiaries from potential misuse of government administrative authority. Indeed, such concerns about limiting use of government authority to administer the Medicare program were evident in the first section of the Medicare statute (Social Security Act, Title XVIII):

> Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency or persons providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person.

The second reason for such widespread use of private insurance companies was pragmatic: the federal government had no national administrative structure or experience with which to run a program as large and complicated as the Medicare program. In 1965, there was no real alternative but to contract with private insurance companies, particularly Blue Cross and Blue Shield which had a nationwide state-based network of plans and the most experience with cost-based hospital reimbursements and UCR physician payments.

Strengths and weaknesses. Medicare's original administrative structure -- and the necessity for changes in function and organization since then -- can best be understood by recognizing that this administrative structure was originally designed to be a bill-paying system. Medicare's administrative systems were not intended to give Medicare managers the ability to control hospital and physician payments to levels set by the federal budget, and they certainly were not intended to monitor or change the practice of medicine. As the Medicare program has gradually come to take on other policy objectives, more functions have been assumed by HCFA or transferred from Medicare's intermediaries and carriers. The most notable of these Medicare administrative changes have been the PSRO/PRO program, the TEFRA/DRG hospital payment reforms, and physician fee increase limits and overpriced procedure cuts.

Over the past twenty-three years, several other strengths and weaknesses of this Medicare management system have become evident. Medicare's unique blend of federal agency policy-setting and delegation of administrative authority to private sector agents represents a noteworthy example of the "contracting out" concept. This has worked well for the Medicare program and allows government to make use of administrative capacity and skills that it does not have. Today, Medicare has a long-standing partnership with a core of well-performing contractors who can take considerable satisfaction in their contribution to realizing the important purposes of the Medicare program. With increasing numbers of private sector third party administrators (TPAs) and utilization review firms, Medicare's basic "contracting out" philosophy seems even more the best one for obtaining good program administration.

The Medicare program's large delegation of discretion to local contractors has also made possible variable administrative practices that probably would not be possible in a federally bureaucratized structure with explicit federal rules and regulations. These arrangements mean that federal policy-makers have not had to promulgate nationally uniform standards. Since the political system has seldom wanted to get the federal government directly entangled with health care providers about their clinical decisions, this has usually proved a satisfactory arrangement.

The basic disadvantages for the federal government of this administrative structure are intertwined with these advantages. The government had to accept, at least initially, wide ranges in contractor efficiency and performance, and there are continuing administrative tensions involved in trying to balance uniformity and consistency in policy implementation with independent contractor

status and the need for contractor-generated and managed initiatives. Somewhat more seriously, the ambiguity in responsibilities between HCFA and its contractors have also meant that each can "point the finger" at the other party when some outside party (such as OMB) inquires why the very broad legal authorities possessed by HHS's managers to deal with "unreasonable" costs and charges and "medically unnecessary" services are not being more vigorously used. As a practical political matter, statutory direction has been necessary to produce marked change in the Medicare program's bill-paying practices.

Ongoing Management Issues If one were starting today to design an ideal Medicare administrative structure, there would be -- from the perspective of efficient program administration -- some major changes in the current contracting system. With advances in computer technologies and telecommunications since 1965, the current intermediary and carrier data processing areas, which are typically on a state-by-state basis, are too small for optimally efficient operations. Similarly, the split between the Part A and Part B processing systems handicaps medical review because it is not possible to obtain a full picture of the care received by a Medicare patient. The contractor franchises established by current law and reliance on a single areawide contractor also inhibit the government's ability to choose the best qualified agents. There have been legislative proposals over several administrations to grant HCFA broader contracting authority to deal with these issues. If such authorities were granted, however, I do not think it would be wise to make much use of them while the Medicare program faces the serious challenges described below. These challenges will require an experienced contractor network and effective partnership between HCFA and its agents.

Major Challenges

Over the next several years, Medicare's administrators are likely to face the most difficult challenges since the program was enacted. These include:

- o Catastrophic insurance implementation -- particularly prescription drug claims processing
- o Physician service volume/medical review
- o Implementation of a new physician payment system
- o Evolution of the Medicare hospital DRG payments
- o Building an administrative structure for long term care services
- o Development of HCFA's professional staff and internal management capabilities to deal with these issues

Catastrophic insurance/drug benefits The implementation of the catastrophic health insurance legislation -- specifically, the prescription drug benefit -- presents the Medicare program with its single most challenging management problem since the original statute was enacted. Some coverage starts in 1990, full implementation in 1991. The key problems are the large scale of the claims processing system that will be needed -- and that most of it must be built. Accounting for whether or not an individual has met the prescription drug deductible requires handling a large number of small claims; up to 500-600 million prescription records may need to be processed annually. This is nearly a 50% increase in the services volume now handled by the Medicare program. A nationwide "point of sale" electronic data system must be developed, with a network of "participating pharmacies", that connects with new Medicare regional processing centers that are separate from the current contractor structure.

Physician service volume and medical review Over the past several years, Congress has enacted new policies or administrative arrangements to deal with hospital pricing (DRGs), hospital use (PROs), and physician fees (fee freeze, MEI limits, overpriced procedure cuts). The major source of Medicare spending increase that has not been addressed has been physician services and other outpatient service volume. In total, the Medicare Part B volume, based on the BMAD reports, will be about 1 billion services this year.[1] The volume increase is now about 100 million services annually.

Let's consider, for a moment, the practical and political difficulties of dealing with these increases through purely administrative means, i.e. through medical reviews and payment denials. To save even 1% of program spending through denial of an average service would require the Medicare program to deny 10 million services, while halving the rate of program increase would require denial of 50 million services. The payment-denied services will already have been provided, and, on unassigned claims, paid for by the beneficiary. One can imagine the degree of administrative effort, beneficiary confusion, provider upsets and communications to political representatives involved in trying to control the Part B volume increase solely through administrative actions on this scale.

The problem of dealing with physician service volume increases through administrative reviews is further constrained because Medicare benefits are a legal entitlement. Payment denials cannot be arbitrary and capricious but need to reflect a determination that services are not covered by the Medicare program or are not medically necessary. Beneficiaries have appellate rights for payment denials, including HCFA and judicial reviews for substantial claims.

I have used this "average" claim example just to forewarn anyone from believing that administrative claims denial alone offers a pain-free approach to this issue. In practice, of course, one would hope to do much better than targeting the average claim, i.e. to focus attention on higher charge services with rapid growth rates that are most likely to be medically questionable and to concentrate on large volume-increase states. Nevertheless, it has seldom been recognized, except by Medicare experts, just how ill-equipped Medicare's highly decentralized administrative systems have been for designing and implementing such efforts. Only in the last year or so have Medicare's BMAD data had the cross-carrier coding consistency which allow for detailed national analyses of patterns of care and service volume growth, and little such work has yet been done with these data.

As I pointed out, Medicare's administrative structure and processes were designed for a bill-paying program. This is particularly true for Medicare Part B. Indeed, one could hardly conceive of an administrative system that is less suitable for reviewing medical practices or controlling volume increases. Claims arrive one a time and are processed as they arrive. A physician bill may arrive for a patient one day, a couple of lab test bills the following week, then a surgeon's bill and, a few months later, several more physicians visit claims, etc. Diagnosis has not usually been reported, nor clinical information. There has been no linkage of A&B claims. Medicare thus has limited ability to review an individual claim in the context of a course of treatment or patient's needs, or to review the appropriateness of an individual physician's practice patterns. In general, the research literature on physicians service reviews -- which is still pretty discouraging in any event -- certainly suggests the individual claim-by-claim review is very

seldom cost-effective. And a bill-paying system cannot make much use of expensive medical professional review, on a claim-by-claim basis, and still carry out its functions promptly and economically.

To deal with Part B volume increases, Medicare will thus need to experiment with new administrative techniques such as profiling of providers, denial of "participating physician" status to physicians with aberrantly expensive practice patterns, integration of Parts A & B records (the Common Working File), use of specialized medical review firms and PROs (for hospital-based care), requiring diagnostic and/or clinical information on some claims, development of medical practice guidelines, and limiting physician billings to once per patient per month so that individual service claims can be reviewed in the context of a pattern of treatment. Nevertheless, I cannot now hold out much hope, based on the literature and international experience, that anything short of major fee reforms and a geographic expenditure target system will be very effective. Such proposals, which the committee may be reviewing in the coming months, would require even more of Medicare's administrators and involve broader changes in its management systems.

Transition to RBRVS system Should the Congress adopt a physician fee schedule, there will be major administrative tasks involved in the transition process. Payment rates will be changed for about 7,000 CPT-4 codes, covering about 1 billion services annually. Some of the most widely used CPT-4 codes (for visits and for surgical services) will probably be redefined. New geographic areas for fee schedules will likely be designated to replace carriers' sub-state areas. Criteria for physician specialty designations may be standardized. New policies will need to be considered with regard to assignment and extra-billing practices.

The actual management of this transition on a "real time" basis, while continuing timely and accurate workload processing, will not be a particularly easy task. The potential for confusion among the 32 million beneficiaries and half a million physicians is relatively high. Adequate lead time, e.g. a 1991 implementation, will be essential. Complicated as a one-year transition will be, a prolonged multi-stage process, involving multiple adjustments of Medicare's payment rates, could be even more difficult and confusing.

Hospital payment policies -- beyond DRGs. The Medicare DRG prospective payment system was enacted about six years ago. With sharply falling hospital margins, it is becoming increasingly clear just how blunt an instrument the national DRG fee schedule is for dealing with our diverse and rapidly changing hospital care system. There will be increasing pressures to adjust DRG rates for individual areas and hospitals and to design a "next stage" of payment policy that will be more responsive to local conditions and preferences. A national appeals mechanism for individual hospital rate adjustments would involve the federal government more deeply in health sector details and politics, which is the outcome DRG reforms were trying to avoid. Another way to deal with financial distress for individual hospitals would be to allow for state review and determinations of special needs within strictly limited totals (e.g. no more than 1% increase in Medicare hospital payments). This system was used during the Cost of Living Council control period for hospitals (1971-74). Other approaches could involve state incentives to establish all-payer rate-setting systems, including Medicare payments. But whatever form these DRG refinements take, new administrative arrangements will need to be considered.

Development of a long term care system A fifth major challenge for Medicare's administrators will be to develop the

foundations for managing long term care benefits for chronically ill elderly and disabled populations. Medicare already covers home health benefits and SNF care, but these benefits have been targeted to acute illness recovery. The limited respite care benefit included in last year's catastrophic insurance legislation broke new ground, and how it is administered will be important for shaping the program's future. In implementing this benefit, Medicare and its agents can develop the expertise needed for designing and administering an expanded long term care program. This is likely to be the major area for new Medicare benefits well into the next century. The next year or two, in particular, can produce a great deal of learning about the users of such benefits, how to assure accurate and reliable assessment of disabilities (ADLs), price setting and control of service use, selection of providers, and quality assurance.

The key Medicare management strategy decisions about administering long term care benefits will be the extent to which Medicare's long term care benefits will be administered as a separate system, will coordinate with, or make use of, state governments' long term care management systems for the Medicaid program. The current Medicaid program has already developed an extensive long term care system, with about $25 billion of benefits annually. The outcome which makes least sense, from an administrative perspective, would be to build two separate federal and state long term care systems, each massive in size, each funding similar long term care benefits for the same elderly beneficiary groups, and each with separate administrative structures for eligibility determination, needs assessment, service definition, case management, provider selection, payment rates, utilization review, and quality assurance.

The Medicare and Medicaid programs have been reasonably well coordinated, for skilled nursing facility benefits, by establishing federal standards for both programs and contracting with state agencies to survey and certify against these standards. This "contracting out" to state agencies for administration of federal long term care benefits offers one model for building Medicare's long term care capacity. Other administrative models would transfer much of the Medicaid program's long term care benefits and tasks to the Medicare program, requiring a much-expanded federal role in dealing with local health and social service providers.

HCFA's internal management capacity Over much of this decade, HCFA has had to deal with growing responsibilities with decreasing personnel and tight controls on promotions, as well as intense OMB oversight. Major Medicare policy development, analysis and advisory bodies, such as PROPAC, PPRC, RXPRC, and the new bipartisan commission on comprehensive health and long term care insurance, have been located in the legislative branch. These have been understandable developments, but they also make it more difficult to recruit, develop and retain the staff HCFA needs to meet its future challenges. Whether one looks to the management challenges of the next five years, or at where the federal government's major growth and most complex problems will be over the next half century, the Medicare program stands out as needing talented managers and program analysts. It will be a major challenge for HCFA's next administrator and his or her successors to develop these career staff and management capabilities.

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[1]Other measures are also sometimes used for workload analyses. A "claim" consists of one or more bills. A "bill" consists of one or more services.

THE LANCET, FEBRUARY 4, 1989

CLINICAL FREEDOM: TWO LESSONS FOR THE UK FROM US EXPERIENCE WITH PRIVATISATION OF HEALTH CARE

PHILIP R. LEE LYNN ETHEREDGE

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IN the United Kingdom (UK), politicians and policy analysts seem increasingly eager to apply lessons from the United States (US) to the National Health Service (NHS). It is clear that the Thatcher Government strongly favours increased marketplace competition and privatisation of health services. There has been support for increased competition,[1] for creation of internal markets within the NHS,[2,3] and for managed care.[4] There has been a rapid increase in US-style employer-provided health insurance benefits. There has been a substantial increase in the number of proprietary hospitals outside the NHS, and in the contracting of hospital services through competitive bidding.[5] There has been a transformation of regional and district management within the NHS, with a system of general management replacing consensus management.[6] And, since the liberalisation of consultant contracts in 1980, the number of consultants engaging in private practice has increased substantially, as has their income from private practice.[7]

These developments reflect an ideology that has strongly influenced health care policies in the US, particularly during the almost eight years of the Reagan administration. Yet today there are growing concerns, among physicians and others in the US, about the impact of the policies on medical care costs, on the commercialisation of medicine, and on physician autonomy.[8-12] As a result of these new market-oriented policies, physicians in the US are now the most litigated-against, second-guessed, and paperwork-laden physicians in western industrialised democracies. Physicians' day-to-day clinical decisionmaking—commonly referred to as clinical freedom—is increasingly subject to review and approval by "case managers" working for employers, insurance carriers, and government financed and regulated professional review organisations. Malpractice suits and administrative costs are multiplying. The growing adversarial relationship with private and public payers and loss of physician autonomy are closely related to the growing view that medical care should be treated like any other private business. The long-term consequences of these trends for the medical profession and medical care in the US are very serious: will medicine continue as an autonomous profession, or will it become increasingly influenced by large purchasers and the ethics of the marketplace? What will be the effect on the clinical freedom of physicians and on the quality of medical care?

What would be the consequences for the UK of adopting a more competitive model for the NHS and expanding the role of private health insurance and private practice? Of a growing commercial influence? The dangers to the NHS of following the mixed public-private model of the US have been pointed out by others. There is a risk that a US-style approach could result in the overuse of technology services at the expense of primary care and in a two-class system of care.[13,14] If the Government succeeds in diminishing, or perhaps even eliminating, the NHS, British physicians may suffer the same fate that awaits their American colleagues.[15] A recent review of private health care in Britain detailed current developments in the UK and defined many of the critical issues of privatisation facing the NHS.[7]

We believe that the dangers to the medical profession of a growing private sector in the UK have not been sufficiently appreciated by physicians. We address here two major dilemmas that have arisen from an increasing emphasis on the marketplace, competition, and commercialisation in medical care in the US: first, diminishing physician autonomy and clinical freedom; and second, the leaping administrative costs and burdens, including those in the physician's office.

DIMINISHING PHYSICIAN AUTONOMY

The Role of Lawyers, Courts, and Regulatory Agencies

The issue of malpractice is a growing concern in the US and the medical profession is sinking in public esteem. When public regard for the medical profession is low, physicians are more likely to be the target of malpractice suits. The number of suits has lately been increasing substantially: studies by the American Medical Association show that the rate of malpractice suits against private practice physicians more than tripled in the first five years of this decade. 37% of US physicians have had a medical malpractice suit against them in their career, and more than ten malpractice claims per hundred physicians were filed in 1985. For some specialities, such as obstetrics and orthopaedic surgery, these rates are much higher.[16]

These developments have resulted in a rapid increase in the cost of malpractice insurance premiums. Professional liability premiums for private practice physicians in the US increased by 22% annually from 1982 to 1986. By 1986, annual premiums were an average of $12 800 per physician; premiums for obstetrician gynaecologists were more than double this amount ($29 300) and were even higher for orthopaedic surgeons ($35 200).[17] In some areas, orthopaedic surgeons and obstetrician gynaecologists pay annual premiums of nearly $100 000.

Because of these trends, defensive medicine—ie, more laboratory tests, more patient investigations, more consultations, and more follow-up visits to guard against malpractice suits—is now a consideration in clinical practice for private physicians. In one study, the costs of defensive medicine were more than 3·5 times the cost of malpractice insurance premiums and accounted for almost 15% of the total US expenditures for physicians' services.[18]

The courts, in their interpretation of antitrust laws, also have had a role in substituting the competitive process of the market for professional self-regulation. The concept of

M. MOODLEY AND A. MOOSA REFERENCES—*continued*

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private sector peer review was challenged in the courts as a result of a suit filed in Astoria, Oregon. The Supreme Court of the United States supported a district court ruling that the professional review conducted by physicians in disciplining a member of the community hospital staff was anticompetitive and that it was subject to antitrust laws.[19] The decision was based partly on the fact that the peer review process was done entirely in the private sector, without government review. The courts have further intruded into professional decisionmaking and standards of care in the applications of technology, particularly for the very young, the very old, and the terminally ill.

The Federal Trade Commission (FTC) has been active in extending general economic theories about competition to physicians. Medical care has become a focus for antitrust litigation, and the FTC is involved in several of those suits. Such developments are relevant for UK health care professionals in view of the recent consultative document *Review of Restrictive Trade Practices Policy* issued by the Department of Trade and Industry in the UK.[20] The document states that there will be no exemptions for professional services "without the merits of each exemption having been established afresh", even though the Restrictive Trade Practices Act of 1976 specifically exempts medical services.

The Role of the Payers

The most intrusive day-to-day pressures on clinical freedom have resulted from the Reagan administration's use of the Government's purchasing power to change the conduct of physicians and hospitals and also from the rapid expansion in private payers' review programmes designed to contain ever-rising medical costs.

The federal Medicare programme, which insures 30 million elderly and disabled persons, was the subject of a new prospective payment system for hospitals in 1983. This system introduced fixed payments per admission based on diagnosis-related groups which encourage hospitals to decrease inpatient lengths of stay and to reduce the resources used in providing care. Hospital administrators suddenly were concerned not only with their traditional area of responsibility—the price of inputs (capital, labour)—but also with the volume and types of services.[21] Also, there was a requirement by Congress for new Medicare contracts with peer review organisations (PROs) designed to control the use and quality of care. These contracts include negotiated objectives between the Federal Government and PROs for review and change of medical practices.

Pressure on hospitals and physicians by the Medicare programme have influenced clinical decisions about the care of the elderly. There was a 9% decrease in hospital admissions from 1984 to 1987 for those aged 65 years and over, and the average length of stay for elderly inpatients decreased by more than a day to 8·9 days.[22] Within 2 years, 1983–85, the proportion of Medicare's surgical charges in hospital outpatient departments increased from 6·7% to 20·5% with corresponding decreases in inpatient surgical procedures.[23]

The Medicare programme has also started to apply new financial pressures on physicians' charges (eg, a fee freeze in 1984) and has stepped up its medical practice reviews. In 1987, Medicare paid less than was charged on 82% of physicians' bills, and reduced charges per bill by more than 25%. The Reagan administration has requested an increase in Medicare's medical review budget for physicians' services from $65 million in the fiscal year 1988 to $127 million in the fiscal year 1989.

The increasing attempts by the Medicare programme to influence clinical decisionmaking have been paralleled by a "managed care revolution" among private sector payers. Managed care, defined as insurer programmes that require previous approval by insurance companies for hospital admissions and concurrent review of lengths of stay, grew from 4% of the private health care market in 1984 to 60% in 1987.[24] Enrolment in health maintenance organisations (HMOs) grew from 9·1 millions in 1980 to 29·3 millions in 1988, and enrolment in preferred provider organisations (PPOs) increased from 1·3 millions in 1984 to 17·5 millions in 1987.[25] Both HMOs and PPOs, which are part of the managed care revolution of the competitive market, use various methods to monitor and regulate physician conduct.

GROWING ADMINISTRATIVE COSTS AND BURDENS

Clearly, the economic record of the competitive market in the US health care system during the Reagan administration necessitates a re-examination of the anticipated benefits from privatisation of health services. National health care spending in the US has more than doubled from $248 000 million in 1980 to over $500 000 million this year—a spending increase of over $1000 per caput. Adjusted for inflation, health care expenditures have been growing at near-record levels. Competition has not been the answer to cost containment:[11] a recent study found that for hospitals, greater competition led to higher prices.[26] Because the cost of health insurance premiums has risen and because increasingly competitive insurance companies have dropped "bad risks" (ie, people who most need health insurance), the numbers of uninsured have increased from 30 millions in 1980 to approximately 37 millions in 1987; millions more are underinsured.[27]

Not so well recognised is the vast amount of paperwork, complexity, administrative burdens, and costs—for physicians, hospitals, patients, and payers—that are involved in the US market-driven medical care review and bill-paying system. Uwe Reinhardt, Professor of Economics at Princeton University, refers to these issues as the B (bureaucratic) factor in medical care.[28] Among his bureaucrats, Reinhardt includes Civil Servants, health insurance company employees, medical review firms, and others who process paper. He contends that the US now has the highest B ratio of health care bureaucrats to health caregivers in the industrialised world and notes that the B factor in the US is rising rapidly. Although overall health care expenditures increased by 85% between 1980 and 1986, Reinhardt found that, according to the official Government accounts of national health spending (which include only payers' administrative costs), the administrative expenses of the US health system increased by 186% from $9200 million to $24 500 million; most of the increase was in the administrative costs of private health insurance which more than tripled from $5100 million in 1980 to $17 800 million in 1986.

Overhead expenses for the US health care system must also take account of physicians' "business" costs that are part of operating private medical practices. Office practice expenses, in addition to malpractice premiums, were an average of $86 000 per physician in 1986. These costs included an average of 2·7 full-time employees per physician, of whom 1·7 were clerical and administrative personnel to handle bills and other paperwork, while 1 was a

nurse or medical assistant. Many physicians already devote 1–2 h a day to administrative matters, and even more of their time is now being taken up in appeals and discussions of fee issues with patients. The total costs of practice, including malpractice, are now about 50% of most physicians' practice incomes. This contrasts with 36% in Canada[29] and 29% in the UK.[30] Hummelstein and Woolhandler[31] calculated that, in 1983, the total US health care administrative costs were $77 700 million (22% of all health care spending). Their estimates included insurance programme administration, and also hospital and nursing home administration and physician office overheads. They projected savings of approximately half of these administrative expenses, about $38 400 million annually, if the US adopted a UK-style national health service.

CONCLUSIONS

During the Reagan era in the US, health care policies have emphasised competition to control costs. However, the market-driven policies in the US have not controlled the public's costs, but they have produced an increasingly frustrated, alienated, and angry medical profession. Physicians, policy analysts, and politicians in the UK would be well advised to carefully and critically evaluate the US experience before adopting piecemeal, policies for the privatisation of the NHS.

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Living with Disability

MAYBE TOMORROW

THE financial position of most severely disabled people has improved greatly in the past 25 years or so. In the 1960s the vast majority had to exist on sickness benefit and supplementary benefit. While undergoing rehabilitation for a broken neck at Stoke Mandeville Hospital I received 13 shillings per week (65p). While a student I was looked after by my wife (also a student), and we lived off one student's grant. Eventually the college managed to obtain 10 shillings (50p) per week for my wife. This had risen to £5 per week by the time I left college. Things are better today, and the disabled now have access to invalidity benefit, attendance allowance, care attendance allowance, and mobility allowance.

Society has recognised that improving the quality of life of the physically handicapped encourages self-respect and dignity, increases independence, and for some lays the foundation for a return to full employment. The days are gone when the physically handicapped (incurables) were treated almost like imbeciles and were confined to hospital wards, institutions, or a dark corner of the family home. Disablement can happen to anyone at any time, and it is comforting to know that the family will not be in debt because of hospital bills or that the victims will not have to go begging on the street corner in a wheelchair, as in some countries. At least there will be someone to look after the disabled person, an attempt will be made at some form of rehabilitation, and the Government will provide some financial support. But having "quality of life" on the National Health Service and social security is an expensive business, very often not cost-effective: the physically handicapped are an extravagant commodity.

Disabled people already on invalidity benefit have some security, but the newly handicapped may be in a less fortunate position under the 1988 Social Security Act. Until the extent of their disability is confirmed, some severely disabled people could lose up to £80 per week in income support. The new Act may well increase payments for many categories of claimant, but a relatively small number of very severely disabled people may no longer be able to support themselves and be forced into institutions. Under the new Act only £60 million from the Social Fund is to be handed out in the form of community grants to meet the needs of disabled people setting up home. Loans (for which a further £140 million is being allocated) are no use: neither are one-off grants for those who have to pay a care attendant every week. Disabled council tenants can be just as badly

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Testimony of

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Thank you, Mr. Chairman, and good morning. My name is Kathleen Lohr, and I am the director of the study that Congress commissioned in the Omnibus Budget Reconciliation Act of 1986 to look at strategies for quality review and assurance in the Medicare program. The study is being conducted by the Institute of Medicine, National Academy of Sciences, and our report is due to you in January 1990. For 12 years before coming to the Institute of Medicine, I worked on quality of care and health policy issues at The RAND Corporation. I would like to highlight five main themes this morning, which are my personal observations and not necessarily those of the Institute of Medicine or the National Academy of Sciences.

First, quality of care in this nation is good, and we have to keep it that way. In protecting the quality of care for the elderly we protect it for ourselves, our children, and our children's children, because, as the dean of quality of care in this country, Avedis Donabedian, has said "The aged are everyman." We are working off a solid, admirable base, and we must not allow it to be eroded.

Second, quality of care, although good, is not uniformly good. It can differ considerably from area to area, beneficiary to beneficiary, doctor to doctor, hospital to hospital. The use of hospital care and of surgical procedures varies tremendously even across small geographic areas of the country in ways for which we cannot fully account. The effectiveness and the outcomes of care can also vary greatly in ways that are not easily explained. These differences can arise from poor technical skills of practitioners, from underuse of needed and appropriate services, and from overuse of unnecessary, inappropriate, and sometime risky services and procedures. Understanding the source of such variations and working to reduce them by, for instance, developing clinical indicators and practice guidelines should benefit all parties, not just the elderly.

Third, care for the elderly is often fragmented and discontinuous in ways that threaten high quality care. We do not seem to have a rational system for ensuring the continuity or "seamlessness" of care across settings and among providers. As we age, knowing our physicians or other providers — and being confident that they know us — is a key to good quality care. This is especially true for the elderly, who may have multiple, complex, chronic conditions. For them, continuity is interrupted when care must be obtained from many different practitioners and specialists, in different and sometimes new or unfamiliar settings, or at home at least partially from family and kin who themselves may be elderly or infirm. We must recognize that physical and financial access to health care generally and whether services are covered completely, partially, or not at all by Medicare are inextricably linked to the quality of health care for the elderly.

Fourth, trust between patients and doctors is important, and we must keep it alive. There is growing uneasiness about a perceived erosion of the mutual sense of trust implied by the phrases the "doctor-patient relationship" and the "art of care." The elderly today are uncertain about where the true allegiance of their doctors lies. The traditional view that the physician should place the interests of the individual patient above all other considerations appears to be slipping away. Physicians and other health care professionals increasingly face many conflicting influences — their traditional professional values, malpractice concerns, utilization management in the name of cost containment — that push them ever farther from their "agency" role for their patients. Once gone, that bedrock of trust in physicians will not be easily, if ever, regained. The growing wedge of mistrust between doctor and patient may severely threaten the quality of care enjoyed by this nation, because, when we are sick, to whom shall we then turn?

Fifth, quality of care is worth it, and we should be investing in it. Maintaining and improving the quality of health care requires resources: people, reliable and valid assessment instruments, and financing. Those resources are in short supply today. The demand for quality assurance calls for increasingly complex programs, yet we devote very little of the nation's attention or wealth to reviewing, assuring, or improving the quality of the

care we pay for. Although the art and the science of quality assurance are increasingly sophisticated, we still have little concrete understanding of the best ways to identify poor (or, for that matter exemplary) providers, to remove poor providers from practice, to assist providers in improving what they do, or to reward providers for superlative performance.

To understand appropriate patterns of service, good processes of care, and expected outcomes of appropriate or necessary care, considerable research on effectiveness and on outcomes is needed. Congress supports the idea that such work should be undertaken by the Department of Health and Human Services; it will contribute greatly to maintaining and improving the quality of health care received by all, not just the elderly. To know where quality-related problems exist, to be able to intervene effectively once problems arise or become critical, and to foster attitudes and programs oriented to the continuous improvement of care, we need a similarly larger investment in the study of existing and emerging approaches to quality review and assurance.

Thank you, Mr. Chairman, for the opportunity to appear here today.

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TWELVE-MONTH UPDATE

DESIGNING A STRATEGY FOR QUALITY REVIEW AND ASSURANCE IN MEDICARE

BACKGROUND

The Institute of Medicine (IOM) is conducting a two-year study to design a strategy for assessing and assuring the quality of care in the Medicare program. Support for the study is provided by the Health Care Financing Administration of the US Department of Health and Human Services under a mandate from the US Congress.

The main purpose of the study is to develop, through a committee of experts, a recommended strategy for quality review and assurance for Medicare beneficiaries in accordance with Section 9313 of the of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). The IOM has also been asked to investigate the adequacy of the standards used in hospitals to meet Medicare conditions of participation for assuring the quality of inpatient services (Sec. 9305 of P.L. 99-509). The two studies will be performed together. The project was officially begun in February 1988, following an October 1987–January 1988 planning phase; the study report is due to Congress January 1990.

In October 1987 the IOM appointed a committee of 17 experts in clinical medicine and nursing, health services research, health policy, law, quality measurement, and other relevant disciplines. In early 1988, a Technical Advisory Panel (TAP) was appointed; it comprises representatives from 14 key organizations in the health care and health policy communities.

In accordance with the eight charges in the legislation, the Study Committee and IOM staff will: (1) assess the current state of the art in quality review; (2) examine existing and emerging quality assurance mechanisms; (3) explore several related issues, such as (a) professional and lay concepts, definitions, and expectations about quality of care and quality assurance, (b) past and present investment in quality assurance programs and resources, (c) gaps and overlaps in administrative and other data that can be used in quality assurance efforts, and (d) the availability of reliable and clinically valid criteria and standards by which to judge quality of care. Through the TAP and study activities, the committee will also pursue appropriate consultation with a broad range of interested parties.

To give specialized attention to key aspects of the study, the Committee has designated *four subcommittees*: The Elderly and the Medicare Program; Quality Review Methods; Quality Assurance; and Patient-Provider Relationships.

STUDY ACTIVITIES ACCOMPLISHED OR UNDER WAY

To date, five *committee meetings* have been held: October 1987 and January, April, June, and October 1988. The *TAP was convened* in April 1988. At least one more TAP and three more committee meetings are planned for the remainder of the study.

Several *background papers* have been commissioned:

- Avedis Donabedian, M.D., M.P.H. (University of Michigan): *"Barriers to Successful Quality Assurance"*
- Catherine Hawes, Ph.D. & Robert L. Kane, M.D. (University of Minnesota): *"Information Systems for Out-of-Hospital Long-Term Care"*
- Michael G. H. McGeary (Institute of Medicine): *"Adequacy of the Medicare Conditions of Participation for Assuring Quality of Care in Hospitals"*
- R. Heather Palmer, M.B., B.Ch. (Harvard School of Public Health): *"Considerations in Defining Quality of Health Care"*
- Gail Povar, M.D., M.P.H. (George Washington University): *"Qualty Assurance: Ethical Considerations"*
- Evert Reerink, M.D., Ph.D. (National Organization for Quality Assurance in Hospitals, the Netherlands): *"International Perspectives in Quality Assurance"*
- Leslie L. Roos, Ph.D. (University of Manitoba): *"Uses of Large Administrative Data Bases to Assure Quality of Care"*
- Lawrence Z. Rubenstein, M.D., M.P.H. (Sepulveda Veterans Administration Medical Center): *"Quality of Care for Older People in America"*
- Andrew Heath Smith, J.D. & Maxwell Mehlman, J.D. (Case Western Reserve University): *"Legal Aspects of Quality Assurance in Medicare"*

In May 1988, eight *focus groups of elderly persons* were held in four sites: New York City, Miami, Minneapolis, and San Francisco. A lengthy report and an executive summary have been prepared. During September and October 1988, eight *focus groups of physicians* in private office-based practice were held in five locations: Philadelphia, New Orleans, Chicago, Los Angeles, and Albuquerque. A draft report is currently being revised.

Two *public hearings* have been convened for this study, as a means of providing opportunities for key organizations and constituencies to make known their views about quality of health care and quality assurance. At the first hearing, in June 1988 in San Francisco, 16 witnesses testified before the committee. At the second hearing, held in October 1988 in Washington DC, 26 speakers participated. Nearly 600 organizations

were asked to provide written testimony for the public hearing process; to date more than 140 organizations have submitted statements. A synopsis of these statements has been distributed to the Committee.

Seven teams, each composed of representatives of the Committee and staff, have participated in *site visits* in seven states (Illinois, Iowa, Minnesota, New York, Pennsylvania, Texas, and Washington). Facilities visited include health care organizations conducting quality review or having a direct interest in or responsibility for quality assurance. More than 45 hospitals have participated as well as six Medicare peer review organizations, eight HMOs, four home health care agencies, and numerous other groups including state hospital associations and departments of health, health care cost containment councils, medical societies, insurers, and business coalitions as well as individual quality experts. Two further site visits are scheduled; California in mid-February and Virginia/Georgia in mid-March. Several shorter site visits are also scheduled for Spring 1989, including visits to Cleveland and Boston. The objective is to give the Committee and staff first-hand experience and an expanded understanding of current and future quality assurance activities by these institutions.

A *congressional briefing* for key staff members of all relevant House and Senate committees was held in July 1988. Various *other presentations* about the study have been made to interested groups, including HCFA agencies, the American Medical Association, the American Medical Peer Review Association, the American Public Health Association, the Joint Commission, the Office of DHHS Inspector General, Prospective Payment Assessment Commission staff, and the Veterans Administration.

ISSUES AND CONCERNS EXPRESSED TO THE COMMITTEE

The focus group discussions have centered on quality of health care concepts and definitions, concerns about the Medicare program and quality of care, understanding quality assurance programs, interest in quality of care information, and recommendations for improving quality.

The written and oral testimony presented through the public hearings has identified numerous quality assessment issues, including process and outcome measurement, data reliability and availability, sensitivity and specificity of problem identification methods, and funding levels for research and for quality review. Among the quality assurance issues identified through the public hearings are concerns about the duplication and poor linkage of efforts in the public and private sectors, a perception of the punitive nature of public sector efforts, legal issues, public disclosure issues, and poor understanding of effective means to improve average practice behaviors.

Facility and organizational participants in the site visits have echoed the concerns expressed by the focus group and public hearing participants. Other issues explored during the site visits include incentives to improve quality, use of outcomes data and review of claims as quality indicators versus screens, internal and external motivations for quality assurance systems, quality assessment and assurance systems that extend beyond inpatient care and across settings of care, local versus national standards, incorporating patient satisfaction and patient autonomy concerns into the assessment process, and the effect of the local health care environment (e.g., availability of health care personnel and other resources) on quality of care.

STUDY SCHEDULE

From February to August 1989, the Committee will consider the structure, topics, and areas of recommendation for its final report, and the subcommittees will move forward drafting major sections of the report. The TAP will also be convened during this time. The study schedule calls for an external review of the final report to begin in early September 1989 and for the final report to be submitted to Congress in January 1990. Dissemination activities will occur during the first quarter of 1990.

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February 1989

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DESIGNING A STRATEGY FOR QUALITY REVIEW AND ASSURANCE IN MEDICARE

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The main purpose of the study is to develop, within a committee of experts, a recommended strategy for quality review and assurance for Medicare beneficiaries in accordance with Section 9313 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). "Among other items, the study shall—

(A) identify the appropriate considerations which should be used in defining "quality of care";

(B) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(C) develop prototype criteria and standards for defining and measuring quality of care;

(D) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(E) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(F) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(G) review mechanisms available for promoting, coordinating, and supervising at the national level quality review and assurance activities;

(H) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care."

The IOM has also been asked to conduct "a study of the adequacy of the standards used in hospitals, for purposes of meeting [Medicare] conditions of participation . . . , in assuring the quality of services furnished in hospitals" (Sec. 9305 of P.L. 99-509). The two studies will be performed together.

To fulfill these purposes, the IOM has appointed a committee of diverse experts; under their guidance and with the assistance of a technical advisory panel the study will: (1) conduct a comprehensive assessment of the current state of the art in quality review; (2) conduct a broad evaluation of the procedures, costs, and adequacy of existing and emerging quality assurance mechanisms; (3) examine a number of related issues, such as (a) professional and lay concepts, definitions, and expectations about quality of care and quality assurance, (b) past and present investment in quality assurance programs and resources, (c) gaps and overlaps in administrative and other data that can be used in quality assurance efforts, and (d) the availability of reliable and clinically valid criteria and standards by which to judge quality of care. In accordance with the legislation, the committee will also pursue appropriate consultation with a number of interested parties, including consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Healthcare Organizations, hospitals, professional societies, and private purchasers of care.

Principal activities contributing to the deliberations of the committee will include:

- two public hearings, to provide opportunities for key organizations and constituencies to put their views about quality of health care before the committee;
- site visits to health care organizations conducting quality review, to provide the committee and staff with first-hand experience with these activities and the views of providers and to provide further understanding of current and future activities by these institutions;
- focus groups among Medicare beneficiaries, to explore major issues relating to attitudes, beliefs, and concerns about quality of care among the elderly;
- staff and commissioned papers, including for instance: definitions of quality of care; the current status of measuring and assuring quality of care; exploration of the major dimensions of concerns about quality of care for the elderly now and in the future; the interface between law and health care delivery and the legal environment within which quality assurance must function; ethical issues in quality of care; and how changing medical record and information systems will affect quality assessment and assurance.

Finally, the committee will produce a comprehensive report that will be transmitted to the Secretary of Health and Human Services and to the Congress. The provisional outline of the final report is as follows:

I. CONTEXT: THE ENVIRONMENT FOR QUALITY ASSESSMENT AND ASSURANCE IN MEDICARE
II. PROBLEM IDENTIFICATION: FUTURE ISSUES OF QUALITY OF CARE IN MEDICARE
III. QUALITY ASSESSMENT METHODS
IV. QUALITY ASSURANCE PROGRAMS: AN INVENTORY
V. QUALITY ASSURANCE STRATEGY FOR THE FUTURE
VI. A RESEARCH AGENDA FOR QUALITY ASSESSMENT AND ASSURANCE
VII. CONCLUSIONS AND RECOMMENDATIONS

Dissemination activities following release of the report will assure that the results of this study are known to all appropriate audiences.

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EFFECTIVENESS INITIATIVE CLINICAL WORKSHOP

Report to the Administrator,

Health Care Financing Administration

Department of Health and Human Services

INTRODUCTION

In 1988, the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services proposed an Effectiveness Initiative; its purpose is to bring the resources of Medicare to bear on the question of what works in the practice of medicine. During this time, HCFA consulted widely with many individuals and organizations in medicine, health financing, and health services and policy research for guidance on this new program initiative.

In August, 1988, HCFA requested the Institute of Medicine, National Academy of Sciences, to recommend clinical conditions that should receive priority attention at the outset of the agency's proposed Effectiveness Initiative. This emphasis on the clinical condition reflected a decision to choose this unit of analysis rather than focus on specific procedures or technologies.

To discharge this task, the Institute appointed a committee according to National Academy of Sciences procedures (following a collaborative consultation between the Institute and HCFA) and convened a one-day workshop on October 27, 1988, preceded by an opening session on the evening of October 26. The committee was chaired by Kenneth I. Shine, M.D., Dean of the UCLA School of Medicine, and comprised the physicians named in the accompanying roster.

The remainder of this report conveys the committee's findings and recommendations pursuant to our workshop deliberations. For a complete record of this project, see the Appendix and its attachments.

COMMITTEE CHARGE

The committee was charged with two responsibilities:

1. To recommend to the HCFA Administrator a small number of clinical conditions (three to five) to receive priority in the early stages of the Effectiveness Initiative;

2. After nominating candidate clinical conditions for initial study in the Effectiveness Initiative, to identify specific dimensions of the management of those conditions that might receive attention.

PURPOSES AND ELEMENTS OF THE EFFECTIVENESS INITIATIVE

The purposes of the Effectiveness Initiative for any given clinical condition can be summarized as follows:

1. To assess the overall merit of competing interventions;

2. To provide information that will:

   a. help clinicians in the management of their patients;
   b. assist and improve the peer review process (e.g., of the Medicare Peer Review Organizations [PROs]); and
   c. aid policy-makers in allocating Medicare resources.

We understand the sequence of steps for the Effectiveness Initiative to be the following:

1. Monitoring of time trends in the use of services by the Medicare population;

2. Analysis of geographic (population-based) variations in the use of services and in outcomes of care;

3. Assessment of interventions through four steps:

   (a) monitoring (as above),
   (b) variations analysis (as above),
   (c) clinical demonstrations and observational studies, and
   (d) randomized clinical trials; and

4. Feedback and education.

According to the committee's understanding, HCFA will do several things in making its databases available for the analysis of effectiveness. First, it will use and improve its own databases as much as possible. Second, when indicated, it will go beyond these administrative data sets to acquire data through clinical demonstration projects and trials. Specially collected information might include data from medical charts (abstracted by the Medicare PROs as part of the Uniform Clinical Data Set effort) and information collected directly from patients or other respondents (as part of patient follow-up activities or surveys). Third, HCFA will collect and improve data through both intramural and extramural projects. Finally, the agency will devote a portion of its resources to making data, whether administrative or clinical, available to the research community through public use tapes and other means, including the proposed national data resource center.

The committee strongly supports this approach. We wish to underscore the view that initial assessments of any clinical problem area cannot provide satisfactory effectiveness data in the absence of prospective assessments, even though these can and will be guided by retrospective review of data. We also want to emphasize our particular concern that interpretations of data concerning prevention, management, and rehabilitation depend critically on adequate risk-adjusted information, properly matched populations, comparison of alternative approaches, and valid endpoints other than mortality; that is, we believe that both the potential utility and the limitations of the HCFA data sets must be clearly understood and acknowledged.

One committee member drew the following analogy between the Effectiveness Initiative and high-altitude observation of the earth: The process begins with a satellite view of the HCFA data to identify the main features of the scene that deserve closer attention. It is followed by U-2 surveillance — a somewhat closer look at those selected area of the terrain that might, for instance, include chart reviews by Medicare PROs. It ultimately results in a focus for detailed low-level reconnaissance based on carefully designed clinical demonstration programs and trials. It was in this context that the committee was pleased to undertake its deliberations and to make its recommendations about the clinical conditions that would provide, initially, the opportunity for satellite observation.

BACKGROUND AND CONDUCT OF THE WORKSHOP

To provide a context and some background materials for the committee, IOM and HCFA staff compiled a set of readings that was forwarded before the meeting (see Appendix). In addition, IOM staff developed a brief exercise that was completed before the workshop. Its purpose was to identify a large set of clinical conditions grouped by major organ systems and disease categories, and then to provide a means of narrowing the set to be discussed at the workshop to a manageable few. HCFA staff also compiled a large array

of data tables on most of the conditions to be discussed; some of this material was distributed before the meeting and the remainder was made available the day of the workshop.

The workshop began with presentations on the effectiveness research initiative by William L. Roper and Henry J. Krakauer of HCFA and a general discussion of the criteria by which the clinical conditions should be selected. Kathleen N. Lohr of the IOM reviewed the homework exercise. The committee then discussed the preliminary list of conditions, selected an interim group of conditions, discussed that group in greater depth, and chose the final set to be recommended to HCFA. We also briefly discussed patient management options for the key conditions that we judged would be important to the Effectiveness Initiative. The executive session focused on the final recommendations to be made to HCFA.

Homework Exercise

The homework exercise was conducted as a modified Delphi process, in which the committee members completed two questionnaire sheets to classify and then rate potential clinical conditions as to their probable importance for the Effectiveness Initiative. IOM staff generated a list of 42 diagnoses judged to represent the primary conditions that should be considered for the Effectiveness Initiative (see Table 1). We were then asked to classify each of these conditions into one of three categories: (1) must be included in the workshop discussion, (2) probably important to the HCFA program, and (3) can be dropped from further discussion. The exercise restricted us from classifying more than 10 conditions in the first (highest priority) category. The third step was to take the 10 (or fewer) conditions we classified as of highest priority and rate them on an "importance scale" ranging from 1 (highest importance to the Effectiveness Initiative) to 5 (lowest importance). We returned these sheets to IOM staff, who compiled the results and reported on them at the meeting (see Appendix for detailed memos).

Of the 14 members of the committee, 13 returned the classification and rating sheets. In our initial response, we collectively nominated 31 conditions as "must be included," including a 43rd condition (urinary incontinence). Based on a simple count of votes, we found that 10 conditions had been so classified by at least six of the committee: angina, breast cancer, acute myocardial infarction (10 votes each); prostatic hypertrophy (9); hip fracture and peripheral vascular disease (7 each); and transient ischemic attack (TIA) without occlusion, Alzheimer's disease, cataracts, and occlusion/stenosis of precerebral arteries (6 each).

When the importance ratings were analyzed, we determined with some simple scoring rules that 14 conditions had clearly higher importance than the remainder; they included all those listed above plus cardiovascular accident and stroke without TIA, depressive disorders, degenerative joint disease, and gastrointestinal bleeding. These conditions — roughly one-third of the original list — formed a core set on which initial discussions at the workshop were focused. A second round of voting on an intermediate listing was also conducted during the workshop.

HCFA Data

Additional background materials were made available by staff of the Health Standards and Quality Bureau (HSQB) of HCFA both before and at the meeting, in the form of two sets of tables that reflect the present capabilities of the HSQB/HCFA data files. The first set of data concerned monitoring of outcomes of medical interventions; the second was based on information partly derived from medical records.

The first seven tables listed below presented data on specific conditions (in the categories of cardiovascular disease, cerebrovascular disease, musculoskeletal disorders, respiratory disease, genitourinary disorders, and gastrointestinal disease); Tables 8-10 aggregated across conditions but showed time trends; and Table 11 was a special analysis of

coronary artery bypass graft surgery (CABG) and angioplasty. Specifically covered were the following topics:

1. Demographics and mortality rates;

2. Patterns of morbidity: Time to first readmission within 12 months (e.g., readmissions and relative risk of readmissions);

3. Patterns of morbidity: Prior admissions within 12 months;

4. Patterns of morbidity: Readmissions within 30 days of first discharge (e.g., percentage of persons at risk; readmissions for specific causes, and length of stay and charges in readmissions);

5. Patterns of morbidity: Readmissions within 31-180 days of first discharge (e.g., percentage of persons at risk; readmissions for specific causes, and length of stay and charges in readmission;

6. Patterns of morbidity: Readmissions within 181-360 days of first discharge (e.g., percentage of persons at risk; readmissions for specific causes, and length of stay and charges in readmissions);

7. Charges for medical care (e.g., total, hospital charges, and charges for various other providers or settings);

8. Cumulative mortality rates;

9. Population-based mortality rates;

10. Year-to-year relative risks of dying after hospitalization; and

11. Time trends in mortality rates and use of coronary revascularization.

The second set of data illustrated HCFA's efforts to acquire and analyze data from hospital medical records in special studies being done through the Medicare PROs. It focused specifically on coronary artery bypass graft surgery and balloon angioplasty, with special emphasis on risk factors predictive of death or of rehospitalization.

PREMISES OF THE EFFECTIVENESS INITIATIVE CLINICAL WORKSHOP

In discharging our responsibilities, we based our deliberations on several premises and understandings that form the context for our specific recommendations:

1. The workshop marks the beginning of a planning and implementation process that will involve other clinical and research experts.

2. Many different points of view will be involved in the planning and implementation of the Effectiveness Initiative. These will include the major units of HCFA, other Federal agencies, and all appropriate private sector constituencies, such as the physician and other provider communities, insurance carriers, and academic and other research teams.

3. The development of information on ambulatory care, long-term care, and quality of care through the Medicare PROs and through external investigator-initiated research is crucial to the effort to expand the relevant databases and to address the issues that the Effectiveness Initiative is intended to examine. We assume existing HCFA data alone cannot answer all questions that might arise from the Initiative; they can identify many problems warranting greater investigation. Thus, we expect that HCFA will

undertake to gather information on outpatient encounters on a diagnosis-specific basis.

4. Data will need to be managed in a careful and responsible way. This includes the publication of findings in peer-reviewed journals and the avoidance of premature release of information. We assume that external review groups will be used extensively at all stages — planning, implementation, and review — of the Effectiveness Initiative program.

ACTORS CRITICAL TO THE DISCUSSION OF CLINICAL CONDITIONS

In recommending clinical problem areas for further investigation, e considered the factors listed below. We also assumed that further efinement of the list of clinical conditions and the selection of specific onditions will use these criteria as well.

1. High prevalence of the illness in the elderly population and/or in particular subgroups of the elderly;

2. Burden of the illness on the elderly, characterized by, for instance, whether it is life-threatening, likely to produce major impairment and disability, or likely to pose a serious decrement to the person's health, well-being, and independence;

3. Substantial variation across geographic areas in the per-person use of services for the condition (i.e., variation beyond that explained by differences in patient characteristics or health resources in the areas);

4. Substantial variation across geographic areas or institutions in the outcomes of care for the condition (i.e., variation beyond that explained by the differences in the severity of illness or sociodemographic characteristics of patients);

5. Relatively high costs (to the Medicare program) of reimbursing for the services provided to patients to diagnose and treat the condition;

6. Alternative strategies for managing the care of patients with the condition that are in dispute or reflect professional and clinical uncertainty; and

7. Reasonable availability of data to address key effectiveness questions, either through HCFA's existing (or anticipated) administrative files or through special studies, surveys, and patient follow-up activities.

In addition, we believe that three other areas of concern should receive attention in the Effectiveness Initiative: screening and prevention of illness; the mental and emotional dimensions (anxiety and depression; cognitive functioning) of any illnesses selected for in-depth study; and clarification of the differences between efficacy and effectiveness. We are especially concerned that special attention needs to be given to the generation and use of reliable and valid outcome measures that relate to functional status and quality of life.

Furthermore, we want to stress the importance of contributions that specific studies on particular kinds of illnesses can provide as prototypes for ways to examine other problems. Thus, we have sought to identify acute illnesses, chronic diseases, and ailments treated by surgery or other procedures that could be considered relatively "clearcut" — i.e., readily identifiable, with straightforward etiologies, relative homogeneity of diagnosis, and clear clinical endpoints. The committee also emphasizes the importance of selecting at least one condition or problem area about which greater ambiguity exists in terms of the ease of defining the condition or

specifying the etiology; hence, we recommend selecting one problem area with heterogeneity of diagnosis and less clear endpoints.

RECOMMENDED CLINICAL CONDITIONS FOR THE EFFECTIVENESS INITIATIVE: FIRST TIER

We recommend five clinical problem areas as the highest-priority conditions for initial investigations of the Effectiveness Initiative; we further recommend a second tier of clinical conditions that could receive later attention (Table 2). Within the two tiers, the diagnoses are not listed in any priority order, because the precise ordering differed according to the measure of importance used.

The top five conditions are the following: angina (stable and unstable); acute myocardial infarction; carcinoma of the breast; congestive heart failure; and hip fracture. As the differences in importance accorded all five conditions are relatively minor, we view them as having essentially equivalent priority. Selecting among them should be done on other grounds, such as key management options of interest and advice from research methods experts.

Immediately following are some specific points raised about the top five conditions. We believe that all five conditions meet most if not all of the criteria for selection enumerated earlier, especially prevalence and cost. In reaching this conclusion, we relied on three bodies of information: the clinical and research expertise of the committee members, the results of the homework exercise and the discussion and subsequent votes during the workshop, and the data made available by HCFA staff at the workshop (which we assume are widely accessible throughout the agency).

The fact that three of the conditions are cardiovascular reflects in part their considerable contribution to overall morbidity and mortality in addition to numerous other questions suggested below. For example, angina is especially common yet responsive to early intervention; acute myocardial infarction represents a medical emergency with many management options in both the acute and post-acute phases; and congestive heart failure in addition is associated with high levels of disability and markedly shortened life expectancy. Hip fracture, by contrast, has low mortality but high potential for disability; it also presents important issues in rehabilitation and long term care. At least three of these ailments (angina, acute myocardial infarction, and breast cancer) also offer a very good basis for studying how a disease is or should be approached at different points in the natural history of disease and hence in different settings, for different population groups (e.g., distinguished by age) and with different strategies. Finally, all of the selected conditions appear to present good opportunities for examining issues related to screening and prevention.

As mentioned earlier, we also discussed some of the key patient management issues relevant to these conditions — prevention/screening, diagnosis, therapy, rehabilitation, and management of related or secondary problems such as depression. An important dimension to this work is that many different patient management options may be appropriate and yet applied quite differently across the nation. Some of these points are noted below as background for future workshops of external advisory panels (for instance, at the proposed meeting of research methods experts).

Acute Myocardial Infarction

We selected acute myocardial infarction for several reasons in addition to the major criteria already mentioned. First, this condition can be very disabling for some individuals yet not for others. Second, this unpredictability of individual outcome (given that a patient survives the acute event) and response to both diagnosis and therapy is itself a worthwhile topic of investigation. Third, new therapies and new data are bringing about great changes and variations in previously established practice patterns.

Other important dimensions to this condition include: (a) prevention -- prognosis and role of exercise; (b) speed of diagnosis, resuscitation, initiation of treatment, transport to sites of definitive care (e.g., use of helicopters, pre-hospital cardiac interventions, etc.); (c) management issues (especially those pertinent to elderly or very elderly patients); (d) use of pharmacologic agents (e.g., thrombolytics, anti-arrhythmics, and anti-platelet agents); (e) catheterization; (f) surgery issues (namely, angioplasty versus bypass); (g) locus of care; (h) rehabilitation (cardiac; general); (i) disability and quality of life (including return to work or daily functioning); and (j) psychological aspects of diagnosis, treatment, and prognosis (anxiety and depression).

Angina

In addition to meeting the major selection criteria noted above, angina is considered an important study condition because it offers good, disputable alternatives to management. Physicians are not in agreement about the preferable approaches, and thus good effectiveness analyses offer promise for changing practice patterns. It has a great deal of impact on disability and patient health status. Angina as a clinical syndrome presents a large set of diagnostic issues, such as the comparative utility or desirability of noninvasive and invasive tests.

Key topics for possible investigation include: (a) risk factors; (b) diagnostic issues: (stress tests, angiogram, and nuclear testing); (c) secondary testing to assess prognosis and to modify treatment regimens; (d) treatment issues, including [1] invasive options (angioplasty vs coronary artery bypass surgery), [2] medical treatment versus invasive therapy, [3] hospitalization questions (threshold for hospitalization, use of intensive care, length of stay); and (e) disability and quality of life with various therapeutic regimens.

Breast Cancer

Apart from the main selection criteria, we conclude that breast cancer takes on added importance because its incidence rises with age; this has special implications for morbidity and mortality in the elderly population as it becomes increasingly aged and more predominantly female. This is the only cancer diagnosis chosen. We believe that it can serve as a model for HCFA studies of similar diagnosis and management strategies in other neoplastic disease.

Other central topics deserving investigation include: (a) screening issues (e.g., who should be screened, how often, etc.); (b) alternative approaches to diagnosis (e.g., mammography, examination, biopsy; use of mammography for diagnosis versus just for screening); (c) staging of disease; (d) therapeutic approaches, such as [1] medical versus surgical interventions; [2] alternative surgical options (e.g., how extensive [i.e., radical] should surgery be in elderly women); [3] use of radiology; [4] use of adjuvant chemotherapy; (e) rehabilitation issues, including use and type of protheses; and (f) emotional dimensions (depression and anxiety).

Congestive Heart Failure

Congestive heart failure represents one diagnosis drawn from a set of common clinical problems (chronic obstructive pulmonary disease, pneumonias, and congestive heart failure) characterized by difficult diagnostic questions (e.g., etiology) and complex management issues. This condition meets the need for including a heterogeneous, complicated condition as one of the final set (apart from the selection criteria already noted). We believe that studying such a condition might be difficult solely with existing HCFA data; hence, part of the rationale for including such a condition is that it provides a model for how to approach similar problem areas in the future (e.g., as a laboratory exercise for methodologic development more than as a means of reaching final answers about effectiveness of interventions).

We believe congestive heart failure is somewhat more useful as a study condition than pneumonia because it is a chronic condition, is somewhat less heterogeneous in its range of etiologies, and is less often a complication of another major (but unrelated) ailment. It is the most common medical reason for hospitalization among the Medicare population and one of the more common reasons for hospitalization (often repeated admissions) in the last year of life. Thus, we also conclude that it offers a special vantage point for studying issues of chronic illness in the last year of life.

Among the key topics that we suggest could be studied are the following: (a) prevention (e.g., treatment of hypertension); (b) diagnostic issues and etiology of illness; (c) medications options, including use of digitalis, vasodilators, and other, newer pharmacologic agents; (d) surgical therapies, including heart transplant; (e) locus of care and threshold of hospitalization; and (f) appropriateness of patient or physician expectations and appropriateness of diagnostic and therapeutic interventions for severely ill patients or those in the last year of life.

Hip Fracture

Hip fracture is the fifth condition we recommend for early investigation because of its overall high ranking on the major selection criteria. Because this is almost exclusively a disease of the elderly, because there is great consensus about the diagnosis, because it is universally treated in hospital, and because some long-term-care data will be available, we believe that hip fracture offers a good test of what the HCFA data bases and systems can do. In addition, in our judgment, no clear consensus exists about certain aspects of the treatment of hip fracture; these areas of contention include length of hospital stay; surgical options (pinning, replacing the femoral head, complete hip replacement); and sequence of surgical interventions. The issues of long-term care and of outcomes functional longer-term are especially important here.

Other key topics include: (a) prevention (e.g., of osteoporosis; of falls; etc.); (b) rehabilitation (prototype programs; short-term and long-term); (c) depression (especially during a long recovery phase); (d) problems of preventing or treating secondary complications (pulmonary emboli, urinary tract infection, pneumonias); and (e) socioeconomic issues related to treatment and rehabilitation (e.g., site of care, length of hospitalization).

RECOMMENDED CLINICAL CONDITIONS FOR THE EFFECTIVENESS INITIATIVE: SECOND TIER

We also identified a second tier of four conditions that were judged important but of second priority. These were cataracts, depressive disorders, prostatic hypertrophy, and transient ischemic attack with or without occlusion or stenosis of the precerebral arteries. Together with the five discussed just above, these conditions were clearly distinguishable from the remaining 30-plus conditions on the original list (Table 1).

Cataracts were viewed as an important area for investigation in part because this progressive disease entity can have a considerable impact on functioning and a patient's ability to carry out ordinary activities. Functional states and patient satisfaction are the most important end-points, not conventional morbidity or mortality statistics. In this instance, the HCFA databases will not be helpful, and additional data will be required. Furthermore, although the diagnosis of cataracts may be quite clearcut, the decision of when to intervene surgically is not. Major questions are raised about the locus of care (outpatient versus inpatient surgery) and the criteria that should be used in choosing the site for surgery. Finally, it clearly accounts for major expenditures by the Medicare program.

Depressive disorders present other special considerations warranting investigation: Despite the fact that special groups among the elderly may

be at extra risk for depression, (e.g., loss of spouse, female living alone, poverty status) we do believe that the population at risk is essentially every elderly person. Detection and accurate diagnosis is a particular problem; it may be a iatrogenic problem in cases where prescription drugs are overused or misapplied; it can be an adjunct to other serious illness and a major cause of morbidity in its own right. In addition, it is treated principally in the ambulatory setting, by formal mental health practitioners and non-mental-health specialists. This condition thus represents another model for additional data collection and use of other functional end points.

Prostatic hypertrophy/hyperplasia offers numerous questions for investigation. These center mostly on the major decision of surgical intervention versus conservative medical management, on choice of surgical procedure when one is to be performed, and on greater patient involvement in decision-making. This condition has, however, been under intense scrutiny by university researchers and clinicians for several years and is expected to be a major target of investigation in research programs sponsored by the National Center for Health Services Research. For these reasons, we concluded that it probably did not merit inclusion in the top five conditions recommended for the HCFA Effectiveness Initiative.

Finally, we combined two of the original conditions (see conditions 12 and 13 on Table 1) to form the diagnostic category of transient ischemic attack (TIA) with or without occlusion, believing that that entity is more understandable to the clinical community than the two diagnoses separately. We judged TIA to be a relatively important study condition in large measure because of the controversies surrounding prevention and therapy (e.g., the use of carotid endarterectomy). It poses some study issues similar to the management of acute and chronic coronary artery disease (i.e., myocardial infarction and angina) but enough separate questions of diagnosis, management, and rehabilitation to warrant individual attention.

Table 1

POTENTIAL LIST OF CLINICAL CONDITIONS TO CONSIDER FOR HCFA EFFECTIVENESS INITIATIVE

The following list of clinical conditions to be considered at the Clinicians' Workshop for the Health Care Financing Administration's Effectiveness Initiative is based on the work already being done internally by HCFA or externally by researchers sponsored by HCFA or by the National Center for Health Services Research. The listing is organized by major diagnosis or diseases classes and, within those, more specific clinical condition areas. (No priority order should be inferred.) Specific procedures related to one or another of these diagnoses are not listed here.

DIAGNOSTIC CLASS AND CLINICAL CONDITION

I. CARDIOVASCULAR/CIRCULATORY DISEASE

1. Angina (stable and unstable)
2. Acute myocardial infarction
3. Valvular heart disease
4. Congestive heart failure
5. Hypertension
6. Bradycardia and conduction defects
7. Tachycardias
8. Aortic Aneurysm
   - 8.a Abdominal
   - 8.b Thoracic
9. Peripheral vascular disease
10. Deep vein thrombophlebitis

II. CEREBROVASCULAR DISEASE

11. Cerebrovascular accident/stroke other than TIAs
12. Transient ischemia attack without occlusion
13. Occlusion/stenosis of precerebral arteries

III. DISORDERS OF NERVOUS SYSTEM AND SENSE ORGANS

14. Parkinson's disease
15. Alzheimer's disease
16. Cataracts
17. Glaucoma
18. Hearing loss

IV. DISEASES OF THE RESPIRATORY SYSTEM

19. Chronic obstructive pulmonary disease
20. Pneumonias
21. Respiratory failure

V. DISEASES OF THE GASTROINTESTINAL/DIGESTIVE SYSTEM

22. Gastrointestinal bleeding
23. Peptic ulcer disease
24. Diverticular disease
25. Cholecystitis
26. Cholelithiasis
27. Hernia (inguinal)
28. Hiatal hernia

VI. DISORDERS OF THE ENDOCRINE SYSTEM

29. Diabetes mellitus

VII. MUSCULOSKELETAL DISEASE

30. Osteoporosis
31. Degenerative joint disease (osteoarthritis/osteoarthrosis)
32. Hip fracture

VIII. GENITOURINARY DISEASES

33. Kidney/urinary tract infection (pyelonephritis, cystitis)
34. Kidney stones
35. Prostatic hyperplasia/trophy

IX. NEOPLASTIC DISEASE (Primary)

36. Breast cancer
37. Uterine cancer
38. Colorectal cancer
39. Stomach cancer
40. Leukemia/lymphoma

X. PSYCHOLOGICAL & PSYCHIATRIC DISORDERS

41. Anxiety states
42. Depressive states

Table 2

CLINICAL CONDITIONS JUDGED TO HAVE HIGH PRIORITY FOR THE HCFA EFFECTIVENESS INITIATIVE

TOP TIER
Acute myocardial infarction
Angina (stable and unstable)
Breast cancer
Congestive heart failure
Hip fracture

SECOND TIER
Cataracts
Depressive disorders
Prostatic hypertrophy
Transient ischemic attack with or without occlusion or stenosis of the precerebral arteries

BENEFICIARY ISSUES IN MEDICARE

Presented by:

MARILYN MOON, DIRECTOR

PUBLIC POLICY INSTITUTE

February 28, 1989

Medicare beneficiaries are very much like health care consumers of all ages: they want high quality health care delivered simply and humanely at the lowest possible cost. The enactment of Medicare in 1965 went a long way to ensure that Americans over age 65 would have access to mainstream medical care at an affordable cost. Medicare continues to be an enormously popular program that offers much to the aged and disabled persons it serves. Nonetheless, the goals of quality, reasonableness, simplicity and low cost are not always achieved.

In my testimony, I will first focus on these areas of what beneficiaries want and then conclude by discussing what Medicare in turn can reasonably demand of its beneficiaries.

ASSURING QUALITY AND REASONABLENESS

The implicit assumption of Medicare when it was established was to assure quality by restricting Medicare to a financing program and relying upon the same system of delivery of care enjoyed by those with private insurance or independent means. Indeed, reimbursement for health care providers was set up to be as much like private insurance as possible.

In the 1980s, two concurrent questions have been raised that affect the quality of care delivered under Medicare: 1) what exactly is quality care for all health care users, and 2) how can we contain costs?

The first question has led to research about how to ensure quality for everyone, including problems that might arise from

receipt of too much care, use of inappropriate services, and technical errors or poor skills of providers.

The efforts to contain costs have indirectly raised concern about quality problems that arise when less than the traditional amount of care is offered. Problems stemming from early discharges for elderly patients who may not be ready to leave the hospital, for example, have often been blamed on the changes that occurred in the way that Medicare now reimburses hospitals. Current discussions about physician payment reform raise similar concerns about the prospects for physicians scrimping on care to their older or disabled patients, or simply refusing to take Medicare patients if physicians are paid less than for treating other patients. Finally, the gaps in coverage under Medicare also raise the spectre of distorting the way in which care is delivered. The problem arises because of a lack of coverage for continuing care for those with chronic conditions, often after a hospitalization. Rehabilitation for hip fracture patients or stroke patients provide particularly telling examples.

Beneficiaries, when surveyed, express little concern over the technical quality of care. They generally indicate faith in their own doctors and in the treatment they have received. They are concerned about quality issues that arise over gaps in coverage, and cost containment-related problems. That is, they point to the lack of coverage for long term care and the lack of drug coverage if you ask them open-ended questions about what is wrong with Medicare. To many beneficiaries, the artificial boundaries between acute and chronic health problems make no sense; they know they need certain types of care and wish the system would meet all their needs.

While some label this a quality issue, it might better fit under the heading of "reasonableness": care delivered when and where it is needed. People are dissatisfied with what they view as arbitrary limits. This is certainly a problem in the areas of long term care and preventive services. Again, beneficiaries

often do not understand why tests that their doctor recommends will not be covered. Would a "reasonable" system deny preventive care that may help one avoid costly and painful health care problems?

Another element of reasonableness to beneficiaries is the ability to choose their own physicians. This is probably one reason why managed care options have been relatively slow to take hold among older patients.

Most efforts to improve the quality of care or make the system more reasonable for Medicare beneficiaries would require additional resources, particularly if the amount of care provided is expanded. But one reason so much attention is now being directed at the appropriateness of services issue is that at least in a few cases we might be able to meet two goals at once: cutting the costs of care while eliminating unnecessary services that harm the patient. Unfortunately, no simple inexpensive solution looms immediately on the horizon.

SIMPLICITY

The complexity of the Medicare program also ranks as a major concern of Medicare beneficiaries. It offers a bewildering maze of benefits and a maddening world of payment and billing that even persons experienced in the world of bureaucratic language and health care claims can not decipher. New businesses are springing up, offering individuals assistance in filling out Medicare forms--often for as much as $25 a form. A survey conducted by the Physician Payment Review Commission found that a third of beneficiaries could not calculate their out-of-pocket liability from the forms they received from the federal government and an even larger percentage did not understand the concept of assignment. And anecdotally, I know any number of health care professionals whose confidence is shaken when asked to help friends or relatives deal with the system.

The problem exists on several levels. Forms indicating what

is covered and what will be paid by Medicare confuse beneficiaries. They often do not know why coverage was denied. Consequently, they can not easily appeal a denial, and in some cases may not even know of the existence of that option. And we know that variations across intermediaries and carriers often result in enormous regional inconsistencies in this "national" program. Services routinely covered in one area will be denied in another.

Moreover, since the system is not clear even to many of the providers, care may not be delivered in some cases on the misperception that it would not be covered by Medicare. This "confusion" can sometimes be used as an excuse, such as in the false claim that "your Medicare days are up and you have to leave the hospital" often made to beneficiaries. Such problems do not only mean that beneficiaries may find the financing bewildering, but also that appropriate care may be withheld.

This area, in particular, is one where Medicare could improve its standing in the eyes of beneficiaries with little added cost. Mechanisms to clarify forms, to ensure uniformity of coverage decisions, and to educate both consumers and providers of health care services could help improve the system. Managed care options could also help here and, indeed, that is why some beneficiaries have joined Health Maintenance Organizations (HMOs). Until better precautions to protect quality are established within the HMO program, however, this approach remains problematic. Physicians might be required to file, without charge, all claims. Claims processing should be streamlined to reduce burdens on both patients and health care professionals.

OUT-OF-POCKET COSTS

The last area of great concern to beneficiaries is the costs that they must bear, not only in terms of the required payments for Medicare services, but also for services not covered by

Medicare. Again, if you ask beneficiaries what they are concerned about, they will likely cite cost problems before they cite quality-of-care issues. Although the introduction of Medicare relieved older Americans of enormous financial burden in 1965, rising costs have resulted beneficiaries devoting an equal share of their incomes to out-of-pocket health care costs.

While considerable attention is devoted to the rapid growth in the costs of Medicare, burdens on beneficiaries also have grown steadily. Over the period between 1980 and 1987, the inflation-adjusted ("real") costs of the Medicare program grew by 50 percent. During that same period, real per capita out-of-pocket costs for Medicare services (including Part B premiums) rose by 49 percent. Average incomes per capita for persons 65 and older grew by only 18.5 percent after adjusting for inflation.

The same calculations for 1980 through 1988 indicate that per capita Medicare beneficiary burdens grew even faster than the per capita costs of Medicare to the federal government. The enormous increase in the Part B premium is largely responsible for that shift.

In large measure, the increased costs to both Medicare beneficiaries and the federal government reflect the overall health care price inflation. Health care cost increases for everyone continue to rise at more than twice the rate of general inflation. Since 1980, for example, every separate health component of the consumer price index has been above the overall index for all goods and services each year (see Chart 1). That means that not only does the federal government's costs for Medicare rise, but the burdens on beneficiaries are also going up--and at a rate considerably in excess of their growth in incomes. The beneficiary burden has risen because some of the government's cost containment efforts during the 1980s shifted an increasing burden onto the patients. Higher deductibles and premiums raised the beneficiary burdens above what they would

otherwise have been. (See Charts 2 and 3 for an indication of the source of growth in Medicare out-of-pocket costs).

If, instead of averages, we focus on a single individual, the statistics would be even more compelling. Incomes to those already over age 65 tend to just about keep pace with inflation and in the case of widows, for example, incomes can fall behind the rate of inflation. And for individuals who are aging, the burden of Medicare out-of-pocket costs grow faster over time than the overall averages for persons 65 and over. Not only do such individuals face the effects of inflation and increased deductibles and premiums, but their use of services also contributes to higher burdens.

Finally, the charts shown here focus on the costs to beneficiaries of Medicare covered services. Other services have also been rising rapidly. Drugs, for example, often lead the list of consumer price increases. Health Care Financing Administration data indicate that the average elderly Medicare beneficiary would have approximately 17 presriptions at a cost of about $360 per year.

The catastrophic act passed last year will certainly help the distribution of burdens on disabled and older Americans, providing relief to those with lower incomes. But because it is fully paid for by beneficiaries, the overall average burden on beneficiaries will not fall as a result of catastrophic. It is designed to be an offset only.

Relief of the cost burdens on Medicare beneficiaries would likely be expensive to the rest of society, unless efforts in areas such as cost containment or appropriateness studies prove effective in holding down costs to everyone. To help beneficiaries, cost containment efforts must find ways to reduce payments to providers that do not jeopardize the quality of care to beneficiaries or indirectly shift more costs onto them. Thus far this has not proved an easy task. The hospital DRG system, for example, has seemed to reduce some unnecessary care, but also

may have harmed quality in some instances and passed on post-hospital recuperative costs to patients discharged earlier than before.

The new emphasis on studying the appropriateness of care as a way of reducing medical costs over time offers some legitimate promise and perhaps too much short term enthusiasm. Much remains to be done to determine both the appropriate norms of care and how to reasonably integrate such knowledge into current medical practice. This "solution" is likely to be one that will not reap benefits until many years into the future.

BENEFICIARIES' RESPONSIBILITIES

Medicare beneficiaires cannot and should not be passive observers of the many changes that will be needed in the changes that will be forthcoming in Medicare. Health care consumers in general need to take a more active role in the treatment they receive and in responsibly recognizing that more is not always better in our health care system.

In addition to the new buzzword of "appropriateness", those who seek a quick solution to the health care cost problems we face often talk about "patient-induced demand". We sometimes hear providers lament that it is the patient who demands extra tests and procedures, who visits the physician inappropriately, who thus unnecessarily increases use of health care. Some of those claims are undoubtedly correct. But to carry this to its logical extreme implies both that the health care professionals are doing little to educate their patients or exercise their own judgement, and that we all know the right type and amount of such care.

One outgrowth of the claim that patients are the source of health care cost increases is the proposal to raise further the out-of-pocket costs that beneficiaries pay. As noted above, that burden is already considerable, however. And studies by the Rand Corporation have found that while higher cost-sharing reduces the

amount of care consumed, the reduction is just as likely to come from necessary care as from unnecessary care. Patients are just not in a position to be able to make good judgements about the care that will be efficacious. Thus, because of the burdens of existing cost-sharing and the problems with making good choices, a more effective approach may be to try to influence public opinion and awareness.

Patient education should be a strong component of our efforts to improve health care in the future, but it is surely premature to blame the patients for not knowing what the professionals themselves do not yet know. We could certainly learn from the other industrialized countries that depend less on treatment and who seem to enjoy similar levels of health status.

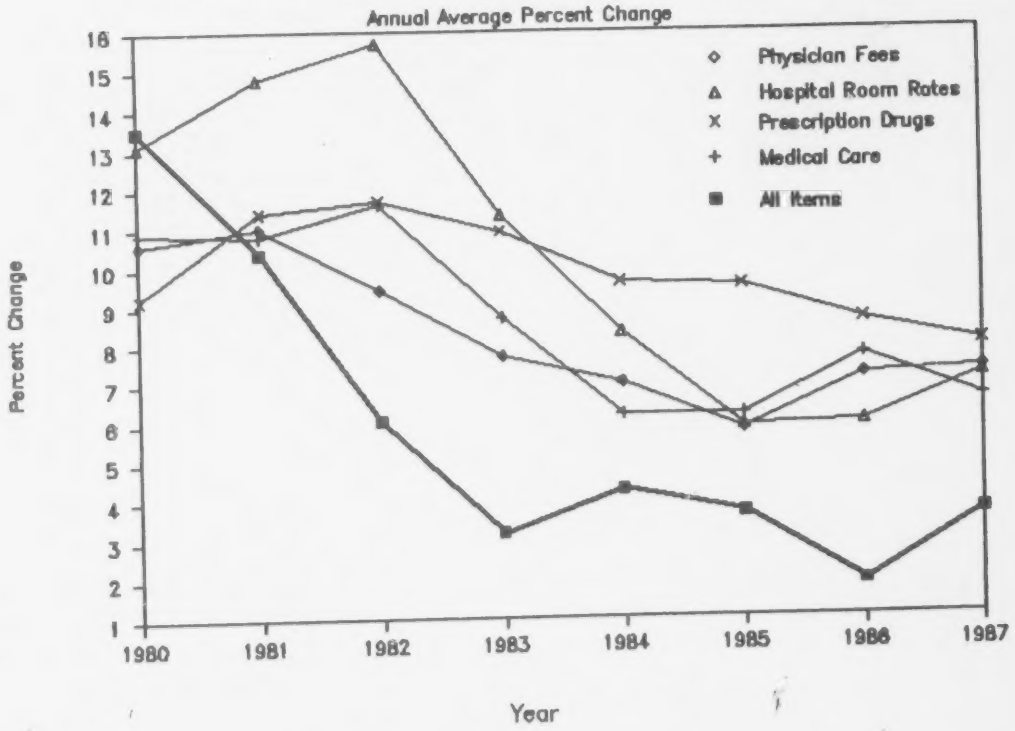
More care is not always better. Some of the growing dissatisfaction with health care in the United States may already be moving us in that direction, but we should not expect changes in attitudes overnight. And we should not believe that older Americans will lead that vanguard. I would look first to changing attitudes among younger people less committed to our current health care norms.

CONCLUSION

The Medicare system stands at an important crossroad. The cost containment efforts of the 1980s and the continuing rise in health care costs, the growing awareness about the lack of coverage for long term care, and the scrutiny being given to quality of care improvements throughout our health care system, suggest that the future will hold considerable change. A major challenge in that process of change will be to protect the integrity of what has been an extremely successful and popular program by keeping the interests of beneficiaries as a primary concern. Certainly the problems of government financing of the system and provider acceptance are also crucial, but Medicare was established to fill an important need in the health care of our oldest and sickest citizens. We should not lose sight of their needs and concerns.

CHART 1

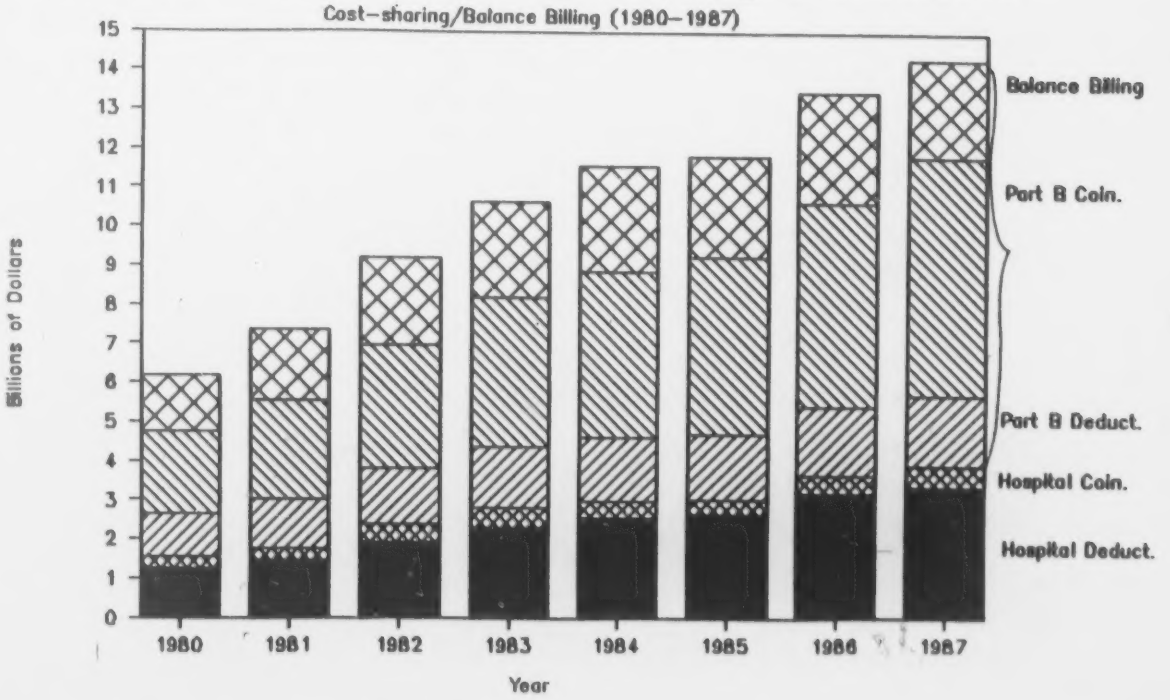
Consumer Price Index (CPI–U)



Prepared by AARP Public Policy Institute, January 1988
Data Source: Bureau of Labor Statistics

CHART 2

Medicare Beneficiary Liability: Aged Enrollees

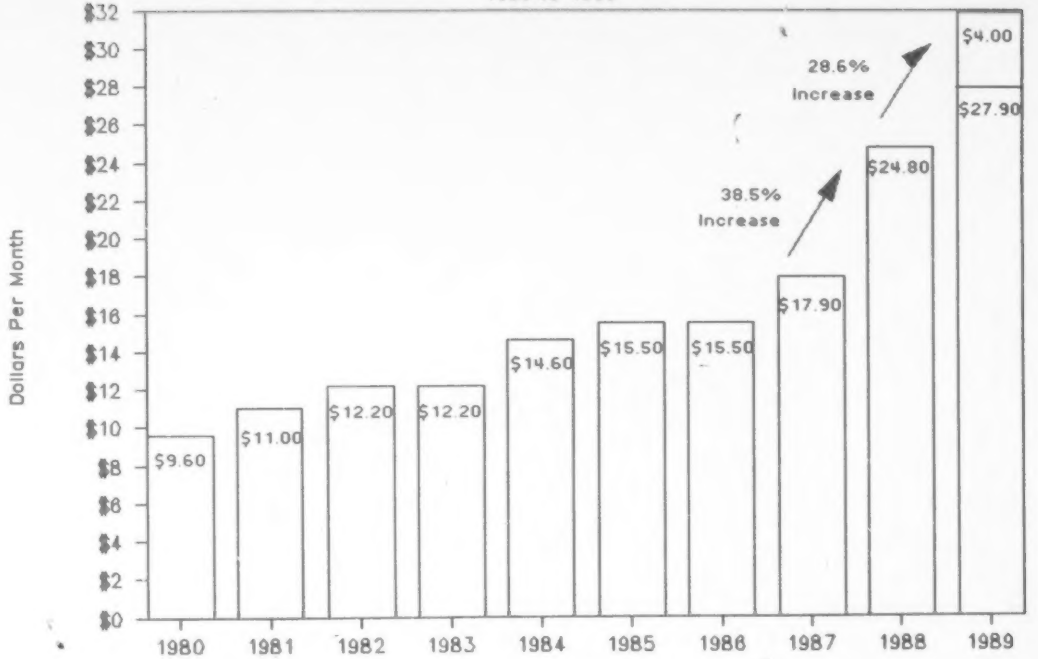


Prepared by AARP Public Policy Institute, February 1988.
Data Source: HCFA,Office of the Actuary, February/March 1988.
Note:Balance Billing includes amounts for both aged and disabled.

CHART 3

Medicare Part B Premium

1980 to 1989



Prepared by AARP Public Policy Institute

Source: HCFA

Donald A. Young, M.D.
Executive Director
Prospective Payment Assessment Commission

Thank you, Mr. Chairman, for inviting me to testify this morning. I am Dr. Donald Young, Executive Director of the Prospective Payment Assessment Commission (ProPAC).

As you know, ProPAC is an independent agency established to assist Congress and the Secretary of Health and Human Services in monitoring and updating Medicare's hospital prospective payment system (PPS).

The Medicare PPS, which is used to pay most hospitals for inpatient services furnished to Medicare beneficiaries, has been in place for over five years. The move from cost-based reimbursement to PPS offered new opportunities and challenges to the government and to hospitals. Many of the opportunities as well as the challenges remain with us today.

My testimony covers three major areas. First, I briefly describe how PPS works, including the annual updating of payments and the policy areas that affect the distribution of payments to hospitals. These issues are sufficiently complex that even those of us who work with them every day have a difficult time keeping up. As I point out, however, these policies are very important in ensuring that Medicare policy is fair to all hospitals. Next, I summarize some of the effects of PPS on the Medicare program and hospitals over the past 5 years. During this time the rate of increase in Medicare expenditures for inpatient hospital services has moderated, due primarily to a decrease in hospital admissions. At the same time, while hospitals did well financially in the early years of PPS, more recently their

financial condition has deteriorated. This is related in part to constraints on Medicare payments. But it is also due to continued large cost increases.

Finally, I conclude with a brief discussion of important issues that affect the relative distribution of hospital payments. The most visible of these in recent years has been the different update factors that have been applied to rural and urban hospitals.

Since the enactment of the Medicare program in 1965, our nation has experienced an unprecedented increase in health care spending, much of it for inpatient hospital services. This growth in spending is displayed in EXHIBIT 1.

Medicare's PPS was enacted in April 1983 in part to control expenditures by giving hospitals financial incentives to improve efficiency and productivity in the delivery of services. There have been numerous legislative and regulatory modifications to PPS since its enactment. Adjustments are necessary to update the system and to correct problems which have been identified. Many of the changes have also been made in the context of our nation's budget deficit. As a result, these changes may have major financial and other consequences for the Medicare program, hospitals and Medicare beneficiaries. Therefore, I would like to very briefly describe some of the details of PPS.

FUNCTIONING OF PPS

PPS works by setting in advance the payment amount a hospital will receive for each patient discharged. In order to set the payment amount, each patient is assigned to one of about 475 diagnosis related groups - called DRGs. This assignment is based on the patient's diagnosis and in some cases the surgical procedure performed during the admission. Each DRG has a weight

that indicates the relative costliness of the DRG compared with all others.

The payment to a hospital is determined by multiplying the DRG weight by a dollar figure called the standardized amount. Because hospitals in different geographical areas have different cost experiences, the Medicare program currently uses three different standardized amounts. There is one amount for rural hospitals, a second for urban hospitals in areas with more than a million people and a third for hospitals in other urban areas. The payment amounts are further adjusted by a wage index reflecting labor costs in the hospital's particular labor market area. Additional payment may be made to reflect added costs related to teaching interns and residents, added costs related to furnishing services to a high proportion of poor patients, and for cases, called "outliers", with extremely high costs or long length of stay.

The three standardized amounts are to be updated each year to reflect the increased costs of goods and services hospitals purchase (measured by the market basket), scientific and technologic advances that improve quality of care, and hospital productivity. The update factor also is adjusted to reflect the mix and complexity of cases hospitals treat.

In recent years rural hospitals received higher updates than urban hospitals. And hospitals in large urban areas have received higher updates than other urban hospitals. In all cases, however, the debate concerning the level of the update factors, as well as many other changes, has been influenced by concerns related to the Federal deficit.

EFFECTS OF PPS AND OTHER CHANGES

Next, Mr. Chairman, I would like to briefly describe some of the

effects of PPS on the Medicare program and on hospitals. As you can see in EXHIBIT 2, the annual growth rate of Medicare spending for inpatient hospital services has slowed significantly in the past 5 years. In fact in 1986 and 1987 there was actually a decrease in expenditures, when you remove the effects of inflation and control for the growth in the number of Medicare enrollees. Total Medicare expenditure growth has also declined from an annual rate of about 8% to an annual rate of about 4%. Again, these figures remove the effects of inflation and of growth in the Medicare population.

At the same time, however, the growth of services other than inpatient care continues at very high annual rates.

The decrease in the rate of growth of hospital spending during the PPS years is due, in part, to the very significant decrease in hospital admissions. As you can see in EXHIBIT 3, however, hospital admissions are again increasing.

The decrease in the growth rate of spending is also due to the significant constraints in Medicare payments to hospitals in recent years. Information on hospital costs and revenues for Medicare patients is shown in EXHIBITS 4 and 5. As you can see, in the early years of PPS, revenues greatly exceeded the rate of inflation as measured by the hospital market basket. Since then, however, revenue per case has grown only slightly faster than the market basket.

EXHIBIT 4 also illustrates a second very important finding. As I mentioned earlier, each year hospital payments are updated to account for inflation and other factors. The hospital industry emphasizes that these updates have been consistently less than the rate of inflation. While this is true, PPS increases in payments per case have always been substantially higher than the

PPS updates, although this difference is less significant now than four years ago. Payments to hospitals have increased faster than the update factor because the payments automatically increase as the reported mix of patients across DRG becomes more complex. As a result, the so-called hospital case-mix index (CMI) rises. ProPAC's calculations indicate that for the first five years of PPS, hospitals received an increase of 11% in payments based on update factors and other policy changes, but additional payments of 21.5% from increases related to case-mix change.

In addition, Mr. Chairman, I want to leave you with another important message. That message has to do with the large growth of hospital costs per case that we and others have documented. In the first year of PPS, Medicare cost per case increased on average 2.2%. Since then, however, costs per case have increased on average over 10% a year.

A frequently used measure of hospital financial condition is the hospital's margin or profit. The margin is calculated using hospital costs and revenues. During the first two years of PPS, Medicare payments to hospitals were quite generous compared to costs. As a result, most hospitals experienced very high margins or profits. This is shown in EXHIBIT 6.

All of this has changed in the past 3 years. Expenses have grown more rapidly than revenues and as a result, hospital margins are dropping.

ProPAC's analysis indicates that average first and second year PPS operating margins exceeded 14%. PPS margins fell to about 9% and then to 4.5% in the third and fourth years of PPS. We believe that the average PPS margin was about zero for fiscal year 1988, when hospitals began their fifth year on PPS. And

while this is just a guess, it is likely that the overall PPS margin for fiscal year 1989 will fall below zero.

The information I have just given you is based on average margins. Another concern, however, is that overall average margins mask significant variations at the individual hospital level. While some individual hospitals continue to have relatively high profits, others have had consistently low or negative margins. For some hospitals, these operating losses may jeopardize survival if they continue. Recently, in fact, an increasing number of hospitals have indeed closed.

HOSPITAL VARIATIONS

This variation in hospital financial condition leads me to the third major area I would like to discuss today. Medicare's PPS is based on a system of averaging. Not all hospitals and patients are average, however.

Recognizing these differences, PPS adjusts for many factors such as the complexity of cases, geographic location (urban or rural) labor costs, and other factors. Special adjustments are also mandated for costs associated with medical education and serving a significant number of low income patients.

The PPS statute recognized a long history of different costs in urban and rural hospitals by providing for separate urban and rural payment amounts. In the years following enactment of PPS, differences in the experiences of these types of hospitals led to decisions to provide separate update factors for urban and rural hospitals. More recently, a separate update factor has also been provided for hospitals in large urban areas with more than a million people.

Differential updates, however, are a very imprecise method of

adjusting for differences among groups of hospitals. Therefore, there have been other legislative and administrative activities to refine payments to better reflect these differences. It is especially important in a constrained budget environment to examine the policies that determine how Medicare dollars are distributed among hospitals.

We also must do much more research to understand why geographic location and other hospital characteristics are associated with higher costs. A fundamental question for Congress, the Administration and ProPAC to continue to address is the extent to which Medicare PPS should continue to be modified to recognize these unexplained cost differences.

In addition to using the update factor to achieve equity among groups of hospitals, improvements are necessary in the definition of hospital labor market areas and in the wage index used to adjust payments based on hospital's labor costs. We need further analysis of the costs of teaching interns and residents, the costs of treating a high portion of poor people and, the costs of outlier cases.

A complete examination of hospital payment equity should go beyond studies of current PPS payment policies. Many other factors contribute to the overall financial conditions of hospitals. The Medicare program should not be expected to solve all financial problems facing the hospital industry. But other issues, such as the impact of the uninsured population, potentially affects continued access to care for all Americans and should not be ignored.

SUMMARY

In summary, Mr. Chairman, PPS has met many, but not all of the goals envisioned when it was enacted. The rate of increase in payments for hospital services has slowed, due to a decrease in hospital admissions and to constrained payments.

PPS experience indicates that when controls are placed on expenditures in one setting, the expenditures increase in less controlled settings. Thus, decreased inpatient hospital admissions have been accompanied by substantial growth of expenditures in outpatient hospital and other ambulatory settings.

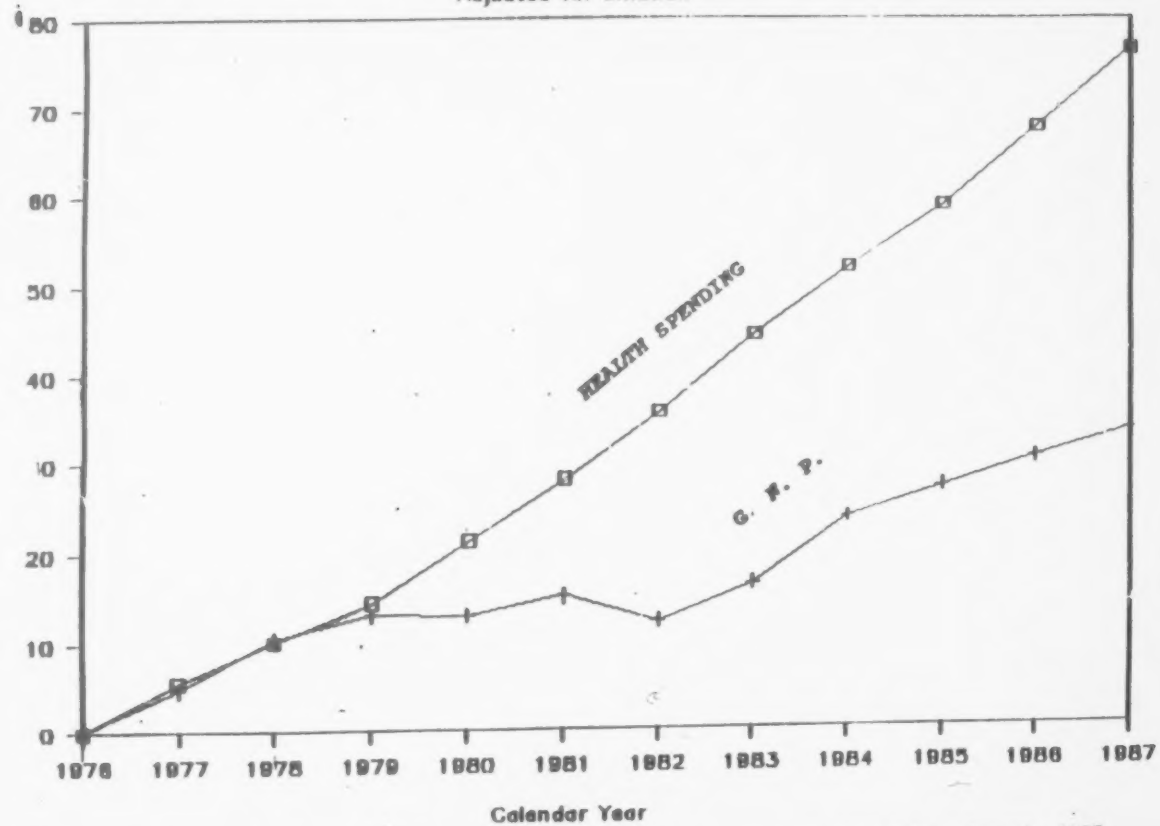
Recently, hospital financial condition has deteriorated, in part due to sustained increases in costs per case. The financial distress of certain hospitals has been especially severe and we are seeing an increasing number of closures.

We must, therefore, continue to carefully examine and modify the components of the PPS payment formula to ensure that our policies are fair to all hospitals. I would be pleased to answer any questions.

EXHIBIT I

GROWTH IN HEALTH SPENDING AND GNP

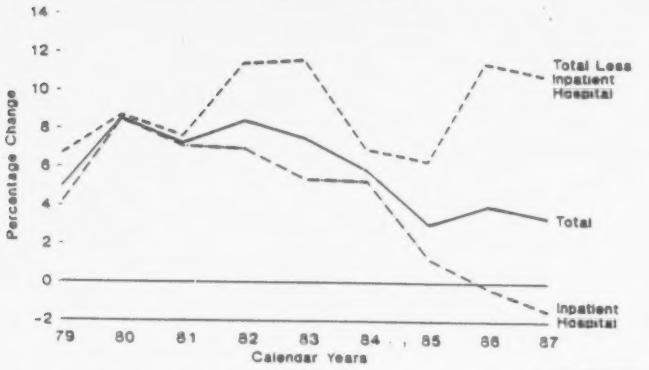
Adjusted for Inflation



Source: Prepar. i by the Staff of the Prospective Payment Assessment Commission, August, 1987.

EXHIBIT II

Figure 5-2. Annual Growth Rates of Inflation-Adjusted* Medicare Expenditures per Enrollee - Total, Inpatient Hospital, and Total Less Inpatient Hospital

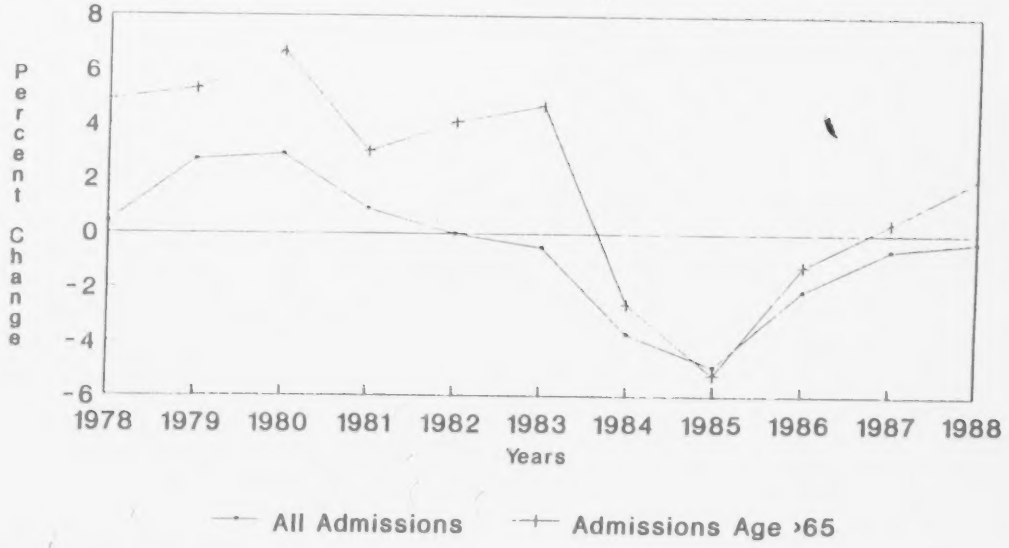


Source: Office of the Actuary, Health Care Financing Administration, as deflated by ProPAC.

* by GNP implicit price deflator

Change in Hospital Admissions

American Hospital Association
Panel Survey Data



Note: 1988 entry represents an estimate based on Jan-Oct

EXHIBIT III

PERCENT CHANGE IN MEDICARE OPERATING COSTS, PAYMENTS AND MARGINS

	UPDATE FACTOR	MARKET BASKET	PAYMENT/ CASE	COST/ CASE	PPS MARGIN
PPS 1 ('84)	4.7	4.9	18.7	2.2	14.3
PPS 2 ('85)	4.5	4.1	10.5	10.4	14.2
PPS 3 ('86)	0.5	3.1	3.3	9.9	9.1
PPS 4 ('87)	1.2	3.5	3.8	10.0	4.5*
PPS 5 ('88)	1.5	4.5	4.5**	9.0**	0**
PPS 6 ('89)	3.3	6.1	6.3**	?	?

* Preliminary Data
** Estimate

EXHIBIT IV

EXHIBIT V

Cumulative PPS Cost and Payment Trends

Percent Change First Four Years

OVERALL PPS MARGIN

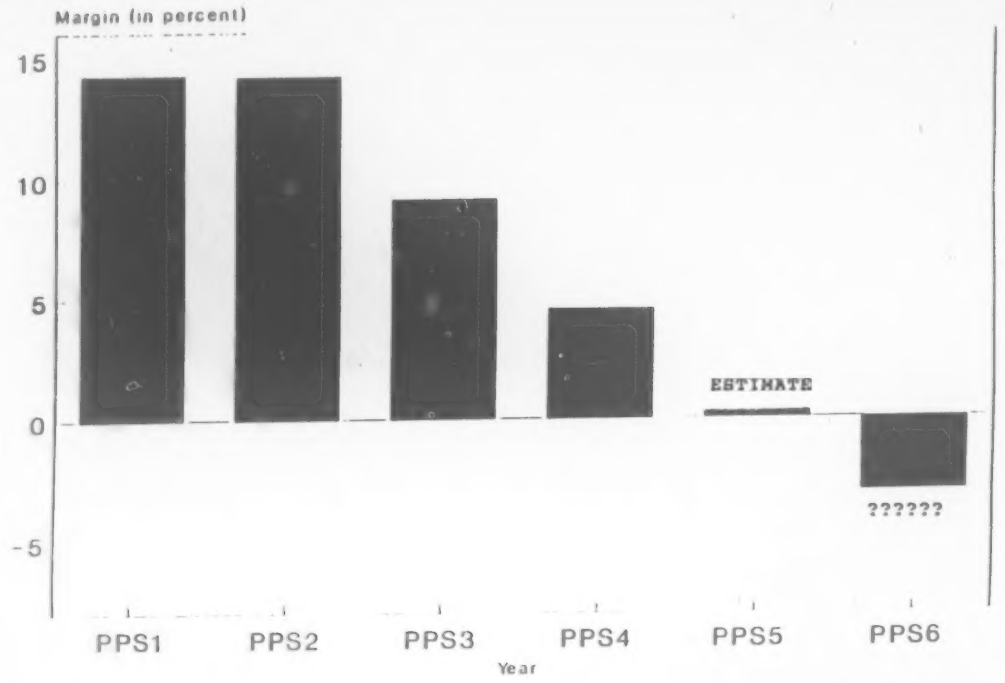


EXHIBIT VI

COMMUNICATIONS

Association of High Medicare Hospitals

Submitted to

Committee on Finance
Subcommittee on Health
U.S. Senate

Hearing on Overview of Medicare Program
March 3, 1989

This statement is submitted by the Association of High Medicare Hospitals (AHMH), an organization representing hospitals concentrating in the care of the aged. AHMH members have a Medicare utilization of 65 percent or more of total inpatient days. The Association welcomes this opportunity to present our views on Medicare hospital payment issues, because our analysis of Medicare hospital cost report data indicates that hospitals with a Medicare utilization of this magnitude have average Medicare operating margins considerably lower than those of hospitals with a lower level of Medicare utilization.

HIGH MEDICARE HOSPITAL CHARACTERISTICS

Based on Medicare hospital data, there are approximately 380 hospitals that meet the definition of high Medicare hospitals adopted by the Association, accounting for approximately 4.2 percent of total Medicare prospective payment revenues. About 30 percent of these hospitals are urban, and about 70 percent are rural. Of the urban high Medicare facilities, about 45 percent are under 100 beds, while about 54 percent have 100 to 404 beds. In the case of the rural high Medicare hospitals, about 96 percent of them have less than 100 beds.

High Medicare hospitals are found in all nine census regions. About 3 percent of these facilities are teaching hospitals, and about 5 percent currently qualify as hospitals serving a disproportionate share of low income patients.

PROBLEMS FACED BY HIGH MEDICARE HOSPITALS

Hospitals serving an unusually high proportion of Medicare beneficiaries are particularly vulnerable to the imprecision and limitations inherent in the present prospective payment system,

which have been exacerbated by the recent budget constraints imposed on Medicare hospital payment.

Lower Average Medicare Margins

High Medicare hospitals have average Medicare operating margins significantly lower than those of all hospitals. Moreover, these margins are declining. For example, preliminary calculations indicate that in the third year of Medicare's hospital prospective payment system (PPS), i.e. hospital accounting years beginning October 1, 1985 through September 30, 1986, the average Medicare operating margin for all hospitals was 8.1 percent, while that for all high Medicare hospitals was 3.9 percent. Projections provided to the Association by the Consolidated Consulting Group -- based on the best information available at the time -- show average operating or "profit" margins in fiscal year 1987 for all hospitals of 6.9 percent compared to an average Medicare loss of 2.0 percent for all high Medicare hospitals.

Actual Medicare data and the projections for fiscal year 1987 reveal average Medicare operating margins for both the urban and rural high Medicare hospitals significantly lower than the respective margins of all urban or all rural hospitals. For example, projections for fiscal year 1987 show that average Medicare operating margins for urban high Medicare hospitals are 9.2 percentage points lower than for all urban hospitals (-1.0 percent for urban high Medicare hospitals vs. 8.2 percent for all urban hospitals), and that rural high Medicare hospitals have margins 3.6 percentage points lower than for all rural hospitals (-3.3 percent for rural high Medicare hospitals vs. 0.3 percent for all rural hospitals).

More Hospitals with Medicare Losses

Not only are average Medicare operating margins for high Medicare hospitals lower than those for all hospitals, but a larger proportion of high Medicare hospitals have suffered losses under PPS compared to all hospitals. Actual Medicare data for PPS-3 show that 38 percent of all hospitals lost money under PPS while more than 56 percent of high Medicare hospitals operated at a loss under PPS. When more recent data become available, they are likely to show a further deterioration in the financial status of high Medicare hospitals, especially since, according to the Prospective Payment Assessment Commission, the hospital market basket -- reflecting the costs of goods and services purchased by hospitals -- increased by about 13.9 percent since PPS-3 while PPS payment rates have risen only about 6.1 percent.

Limited "Cost-Shifting" Opportunities

It is also important to note that, in view of their heavy reliance on Medicare revenues, high Medicare hospitals have a very limited ability to recover inadequately reimbursed Medicare costs from other sources, including other payors. Obviously, in a time of intense competitiveness in the provision of hospital services, high Medicare hospitals cannot simply pass along Medicare losses to the relatively small number of non-Medicare patients, expecting other payors to willingly shoulder these Medicare shortfalls.

RELIEF SOUGHT

The AHMH has met with officials of the Health Care Financing Administration (HCFA) and with the Prospective Payment Assessment Commission (ProPAC) to discuss our concerns. The Association has urged both HCFA and the Commission to devote some of their analytic resources to examining the problems of high Medicare

hospitals. Specifically, we have indicated our belief that data and analysis relating to high Medicare hospitals should be included in regulatory impact statements accompanying PPS rules and other proposed hospital payment regulations. Also, the regular reports to the Congress about the impact of PPS prepared by HCFA and ProPAC should include an examination of high Medicare hospitals, much in the same way that these reports consider the impact on other special classes of hospitals, such as those serving a disproportionate share of low income patients.

In its March 1, 1989 report, the Prospective Payment Assessment Commission noted the concerns that have been raised about the vulnerability of hospitals with high Medicare utilization and indicated that it "...plans to monitor the relationship between the proportion of Medicare patients and financial performance under PPS."

The Association believes that the worsening financial position of high Medicare hospitals argues for a change in the PPS payment methodology that would treat these facilities more equitably. We welcome the fact that several bills introduced early in the 101st Congress include provisions recognizing that certain "Medicare-dependent" rural hospitals warrant special protection under Medicare's hospital payment system. However, these bills focus solely on the problems of small, rural Medicare-dependent hospitals, while the AHMH believes that the current PPS also disadvantages urban and larger rural high Medicare hospitals as well. We also note that our definition of high Medicare hospitals makes use of inpatient days, rather than some other measure of utilization, in a manner not unlike that chosen by the Congress in identifying hospitals serving a disproportionate share of low income patients.

The Association recommends that the Congress address the problems of all high Medicare hospitals (i.e. all hospitals with Medicare utilization of 65 percent or more of total inpatient days). For urban high Medicare hospitals, we recommend a per case adjustment based on the difference between the average Medicare operating margin of urban, high Medicare hospitals and all urban hospitals. Similarly, we recommend a per case adjustment for rural high Medicare hospitals based on the margin differential between this class of rural hospitals and all rural facilities. To illustrate, if the latest available Medicare data showed a 5 percentage point difference between the average Medicare operating margin for urban high Medicare hospitals and all urban hospitals, the approach recommended by the Association would result in a 5 percent upward adjustment in Medicare payment amounts for the high Medicare facilities.

We believe that such a payment adjustment would help assure that hospitals concentrating in the treatment of Medicare beneficiaries would be treated more equitably than they are under current hospital payment rules.

We look forward to working with the Committee as it grapples with the problems faced by the nation's hospitals, including high Medicare facilities. We would be pleased to provide any additional information that would be helpful.

Statement
of
The American Occupational Therapy Association, Inc. (AOTA)
on
Improvements to the Medicare Program

Submitted to the

Subcommittee on Medicare and Long Term Care
Committee on Finance
United States Senate

March 3, 1989

Mr. Chairman:

The American Occupational Therapy Association, Inc. (AOTA) is pleased to have the opportunity to submit this statement on improvements to the Medicare program in conjunction with the Subcommittee hearings held on March 3, 1989.

The Association represents the professional interests of some 40,000 occupational therapists, occupational therapy assistants and students of occupational therapy. Members of our profession provide services to Medicare beneficiaries in hospital inpatient and outpatient settings, physician offices, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, hospices, rehabilitation agencies and clinics, and through home health agencies. In addition, Medicare certified occupational therapists in independent practice render outpatient occupational therapy services to beneficiaries.

We wish to bring to the attention of members of the Subcommittee a deficiency in the Medicare home health benefit as it is currently structured. In order to qualify for services, a beneficiary must be under the care of a physician who certifies that the individual is confined to the home and requires intermittent skilled nursing care, physical therapy or speech therapy. If the beneficiary requires one of these qualifying services, then occupational therapy services may also be provided. In addition, occupational therapy services may continue to be provided after the individual's need for qualifying services has ended.

Occupational therapy personnel and the beneficiaries they serve are confused and frustrated by a Medicare policy that allows beneficiaries to receive medically necessary occupational therapy services under the home health benefit only if they are in need of another service. Requiring a multitude of services when a person needs only one is neither logical nor cost effective, and we urge the Subcommittee to consider legislative modifications that would establish occupational therapy as the fourth qualifying service under the Medicare home health benefit.

Occupational therapy is an important part of the home health care provided to many Medicare beneficiaries. It is especially necessary for individuals who are victims of strokes, heart attacks, diabetes, multiple sclerosis or spinal cord injury, who are disabled by severe arthritis, or who have suffered physical injury as a result of a fall or some other accident.

Occupational therapy focuses on increasing the patient's functional level. The application of this service often plays a critical role in ensuring the patient's full recovery, the prevention of further disability, and a successful readjustment to the home and community environment. The occupational therapist will establish a treatment program designed to increase the patient's level of physical function. The therapist will also teach the patient, and those family members or others who will care for the patient, compensatory techniques which permit the patient to function more independently with feeding, dressing, and personal hygiene activities. The therapist will also make splints and self-help devices which either protect against joint deterioration, e.g. with an arthritic patient, or make the individual more independent, e.g. by providing stability of the wrist joint which will allow a person with severe wrist deterioration to use their remaining hand function. Finally, the therapist will recommend changes in the physical environment of the home to promote increased patient independence under the safest conditions possible.

In many instances only occupational therapy is required to meet the

medical need of homebound beneficiaries. The current restriction on ocupational therapy services undermines the principle of providing quality health care at the lowest possible cost to the Medicare program. Specific patient conditions where only occupational therapy might be needed include the following:

- The patient who has been ambulatory and functioning independently in her home calls her physician because she is no longer able to walk safely and has fallen several times. The physician determines that she has decreased knee and ankle motion bilaterally due to accelerated osteoarthritic changes. The physician orders a home health occupational therapist to design and fabricate night resting splints to increase knee and ankle motion and prevent further deformity. Without these splints, the joints will permanently lose range of motion, and the patient may never walk again. The physician's alternative to occupational therapy in the home is admitting the patient to a hospital or transporting her by ambulance to a community facility or the outpatient department of a hospital.

- The diabetic wheelchair-bound patient with bilateral above-knee amputation, partial blindness, and decreased sensation in her hands due to diabetic neuropathy has been discharged from the hospital soon after she was independent in wheelchair transfer techniques. She needs the continued services of an occupational therapist to teach her an acute awareness of her sensory deficits and compensatory techniques to overcome her partial blindness and poor hand sensation. Without the occupational therapy program, complications such as accidental burns in the kitchen and decubiti can easily occur.

- The homebound patient with chronic lung disease and subsequent weakness, decreased endurance, and a continuous need for oxygen has difficulty performing daily functional activities. She is unable to pace her activities with her limited breathing capacity, and her physician has ordered occupational therapy to see if an energy

conservation program will allow the patient to perform the necessary daily activities to remain at home and avoid nursing home placement.

- The patient with a long history of multiple sclerosis is experiencing increased difficulty with coordination due to spasticity and is no longer able to feed herself. She needs an occupational therapist to decide whether adaptive equipment would allow her to regain independence. Only the occupational therapist is skilled in assessing and providing this type of equipment, and no other service is necessary.

In all of these instances occupational therapy would be provided in accord with existing medicare coverage criteria as specified in the intermediary manual for home health agencies. These criteria require that occupational therapy be prescribed by a physician, be performed by a qualified occupational therapist or assistant, and be reasonable and necessary for the treatment of the individual's illness or injury. Occupational therapy is considered reasonable and necessary when "an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time."

Cost considerations are clearly essential in assessing any proposal to revise existing coverage of services under the Medicare program. At the request of Senator George J. Mitchell (D-ME), the Congressional Budget Office (CBO) has prepared an estimate of the potential cost of allowing individuals to qualify for Medicare home health services on the basis of a need for occupational therapy services. The CBO estimate projects costs directly attributable to expanded utilization of occupational therapy services to be $16.8 million in fiscal year 1990, and $54.6 million over fiscal years 1990 through 1992. The CBO estimate also assumes, however, that beneficiaries qualifying for home health services through their need for occupational therapy will also require the services of a home health aide at least as often as they need occupational therapy. As a consequence,

the estimate assumes an additional $31.2 million in home health aide cost in FY 1990 and $101.4 over FY 1990-1992.

We believe, however, that the CBO assumptions overstate the costs because they fail to take into account several factors. First, the CBO assumption that home health aide services would be provided as frequently as occupational therapy services substantially overstates utilization patterns based upon reports from our membership. Secondly, CBO does not take into account cost savings that would accrue to the program by eliminating instances that likely occur under current law where qualifying services of questionable need are prescribed in order to meet the beneficiary's need for occupational therapy. Finally, it fails to assess savings resulting from the avoidance of recurring disability with its accompanying need for a return to more costly care in a hospital or nursing home setting when beneficiaries are unable to receive covered occupational therapy under the existing home health benefit. In summary, it is our view that the net cost increase to the program would be minimal in light of the above stated reasons and in view of the fact that it would not affect large numbers of beneficiaries. However, for those beneficiaries who would be affected, their need is critical.

We believe that adding occupational therapy as a qualifying home health service is a reasonable and much needed improvement which will significantly strengthen the home health benefit and the Medicare program. We urge the Subcommittee to view this proposal favorably and consider incorporating it into any Medicare legislative initiative being contemplated this year.

GOVERNMENT AND MEDICINE
IMPROVING THE MEDICAL SYSTEM

AN OPHTHALMOLOGIST'S PERSPECTIVE

WILLIAM J. RAND, M.D.
Diplomate American Board of Ophthalmology
Fellow American Academy of Ophthalmology
Member American Society of Cataract and Refractive Surgery
Member Outpatient Ophthalmic Surgical Society
Director, The Rand Eye Institute

A government that has concern for the welfare of the individual must seek to provide medical care that is accessable, affordable and of the highest quality possible, without losing sight of the incentives that are necessary to encourage the highest standards of excellence. The people of the United States need and deserve a system of medical care that serves them with excellence and not with a standard of the lowest common denominator.

IMPROVING THE HEALTH CARE SYSTEM: CONSIDERATIONS

The following represents a series of recommendations for Congress to consider as it evaluates potential changes in the health care system. Included is an identification of several serious misperceptions that urgently need to be corrected. This is an analysis from the perspective of an Ophthalmologist who is one of the most experienced eye surgeons in the country. He is involved intimately with the finance and management issues in Ophthalmology, as the Director of a major center of professional excellence, the Rand Eye Institute, located in Pompano Beach, Florida.

Legislative changes, in order to be improvements, must be well thought out and understood. Far reaching and irreversible consequences will result from any legislative action in the health care field. Inappropriate action could reduce the standards of health care by impairing the abilities of those who traditionally have been the innovators in medicine and who, by example, have set and continue to raise the standards of care in this country. Congress must carefully assess the risks and benefits inherent in any legislative action it may enact in the health care field.

A number of studies have been commissioned and have offered suggestions as to what should be done to Medicare and to the health care system. Some of these studies have been greeted with emotional opposition and some with allegations of scientific inacuracy. Some of the studies and recommendations have been so complex that they are difficult to interpret.

Any legislation in the health care field must be precisely directed, accomplishing the intent of the legislation without "fallout." Unwanted and unexpected side effects of legislation can needlessly destroy or reduce the incentives that encourage quality care. An upheaval in a system as complex and interdependant as the American health care system would not be in the best interests of this nation.

A simplified and to the point series of recommendations are made in order to help the government achieve the goal of cost containment while curbing system abuses and maintaining patient access to the finest quality health care.

RECOMMENDATIONS FOR IMPROVING THE HEALTH CARE SYSTEM

1) Congress should focus it's activity to accomplish it's imperatives with minimal legislative fallout.

> The proper course of action is for Congress to pass intelligent laws addressing each problem specifically and directly, preserving intact the positive aspects of the American Health care system. It is important for congress to resist the pressures for a legislative upheaval in a complex and interdependant system.

2) Congress should take action for cost containment and to assure the fiscal integrity of the Medicare system.

Expenditure targets may be unpalatable, but necessary. If it is necessary to impliment a percentage reduction for medicare savings, the required percentage reduction should be calculated and should be evenly spread out over all providers. A precedent for this exists in prior implimentation of automatic Gramm-Rudman reductions. These reductions would not be unbearable and would not shock the system.

3) Patients of limited income must be protected from increased costs that might result from congressional action.

This can be accomplished by a program of voluntary or mandatory, if necessary, medicare assignment for low income medicare patients.

The Internal Revenue Service can be directed to issue a special identification card (a green card hypothetically) to each Medicare recipient with an income of less than $12,000 per year.

Congress would not have difficulty gaining the cooperation of Physicians. Most physicians would welcome the opportunity to know which patients need special consideration and would cooperate willingly. If necessary Congress could mandate this later.

There is no shortage of physicians who will gladly accept Medicare assignment for all services, even with reductions. Very few doctors work at capacity. Only those who want to pay more for a specific individual physician will do so and they can change doctors if they do not want to pay more.

4) Congress should require that any surgical service that might be suspected of abuse be pre approved, not by a PRO, but by the patient, utilizing the system of "informed consents."

Presently, cataract surgery is pre approved by communicating by mail or over the phone with a secretary or nurse at the PRO, who varifies that the exam data confirms the indication for surgery. The PRO merely checks the data against a list of guidelines. A patient could do this as well and would be more interested in confirming the indications for surgery. Therefore, this costly PRO system could be replaced with a more effective patient oriented system.

The patient can be required to read, understand and sign an informed consent document that lists the criteria for surgery. A witness other than the physician should sign as well.
This becomes a legal document that patient and Doctor will consider important and will have the force of law just as the informed consent for surgery.
The original document should be required to be attached to the medicare claim form for payment.
The patient will be most interested and will certainly ask his or her physician why there may be any deviation from the printed indications.

In this manner, government knows that the patient truely understands the accepted indications for cataract surgery. The patient will be a watchdog right in the physicians office. Informed consents of all kinds are "legal documents" which will not likely be abused.

5) Congress must address the issue of cost containment in medical malpractice insurance premiums.

Virtually anyone can obtain a $25,000 settlement for an alleged injury since it costs more for an insurance carrier to litigate a valid defense.

Congress should establish system of "out of court" arbitration panels and encourage the definition of a list of potential complications that can

occur as a consequence of medical or surgical treatment that would be considered to be "non litagatable" occurances.

6) Congress should attempt to assure the availability of affordable health insurance for anyone who wants it.

If Congress were to adopt a system of comprehensive socialized medical care, taking responsibility for all facets to the health care system, an administrative and bureaucratic nightmare would ensue. All the ills of the foreign socialized medical systems would befall this country. Because of the political considerations unique to this country, the cost saving benefits would not automatically result.

Free health care should not be considered to be a right of the individual, as in communism or socialism. All persons should have the right to obtain affordable health care. They should pay only what they can truely afford.

Congress should allow people to purchase into the medicare or medicaid plans for predetermined annual premiums. There could be a sliding scale according to personal income with inflation increases annually. Medicare benefits could be priced higher than medicaid, with selection of options at the discretion of the purchaser. Limitations of expense could be based upon a certain percentage of income.

This would be beneficial for those who might be denied insurance for preexisting medical conditions such as diabetes or heart conditions. Those with low to moderate incomes would find insurance affordable. Some may exercise the option to self insure.

This would result in universal health care for those who want it, only lightly supported by government, as opposed to other plans that could severely impact upon business or taxpayers.

7) Congress should reaffirm that a free enterprise system of incentives in which physicians and corporations actively persue their own individual interests is not inherently wrong. Indeed it is in the best interest of the country that every person achieve their maximum potential. This system has served us well throughout history.

The Medicare participating physicians program should be ended. It is costly to administer and a discrimination against non participating physicians and their patients.

Studies show that a disproportional number of service billings come from participating physicians. This may be a result of lack of patient supervision in the billing process. The more a patient participates in the payment or co-payment for medical service, the more he or she becomes a watchdog for medicare system abuses.

Support for Health Maintenance Organizations (HMO's) and capitation disincentive to care sysyems should be eliminated. A congressional investigation into the abuse of HMO patients should be convened an would reveal devastating testimony. Almost every private practice Doctor has witnessed HMO practice irregularities.

8) Congress should free the medical system from unnecessary government imposed restrictions that do not in themselves provide any cost savings.

The Medicare "Maximum Actual Allowable Charge" limits and the "Special Charge Limits" are primary examples of fee restrictions that do not reduce Medicare expenditures at all. And they severely impair the delivery of extra levels of medical and surgical care such as is found in centers of professional excellence, and they limit access to the finest physicians.

The Relative Value Study has no potential for cost savings that could not be generated by percentage reductions in the present fee schedules.

The RVS has been accused of flawed methodology, of being hastily put together, with resulting inappropriate and inaccurate conclusions. It has been likened it to a Phd thesis, without relevence or need. Indeed, it might resemble unneccesary surgery.

Inequity in reimbursement was not a problem until the RVS promised a segment of the medical community an increased level of reimbursement. The RVS attempts to replace the logic of twenty five years of the medical marketplace with speculative conclusions. It is not worth the effort and risk to replace the consumer driven value scale we have now.

DELIVERY SYSTEMS AND PROVIDERS

Further Medicare Cuts Appear Inevitable, Given Program's Growth Rate, and Potential for Catastrophic Care Spending

by Walter J. Unger

Because of the immensely powerful political and demographic forces at play, changes in the rapidly growing, and popular Medicare program are inevitable.

On one hand, health care providers are increasingly dissatisfied with what they see as inadequate compensation rates under the program. On the other hand, Medicare's aged and disabled beneficiaries complain about their rising out-of-pocket health-care costs and the specter of financial ruin due to ill health. Caught in the middle are the federal government, medical product and service vendors, and America's taxpayers.

In one way or another, the Medicare program touches the lives of most voters. It provides economic security not only for America's 32-million aged and disabled citizens but also for their relatives. It is a mandatory tax burden for 130 million workers. It pays for nearly one-fifth of the costs of America's $550 billion health-care industry -- a field which employs more than 8 million persons.

For 500,000 practicing physicians and 5,700 community hospitals, Medicare is typically their largest single source of income. On average, Medicare pays for 21% of all physician services and 29% of all hospital services. No other purchaser has such an enormous influence on the health-care marketplace. As a result, the future economics of hospitals and physicians is inextricably linked to Medicare's future.

Enacted in 1965 as a part of President Lyndon Johnson's Great Society agenda, the Medicare program was originally seen as a way to bring the elderly into the mainstream of American medicine. Twenty-three years and more than $700 billion dollars later, it is increasingly viewed, by Congress, as a lever to influence the nature and costs of American medicine.

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Program Size, Growth Rate Stand Out; Political Expediency And The Axe

Medicare is now the second largest domestic program in the federal government's budget. Its outlays will, for the first time, top $100 billion in 1989 -- double their 1982 level and quadruple their 1978 amount. At the current rate of growth, its outlays will exceed $150 billion by 1993.

- **Provider protests to the contrary, Medicare has been subject to a "disproportionately" high burden in federal budget controls because its rate of growth continues to run ahead of other federal programs.**
- **Political expediency plays its part -- defense and Social Security are sacred; Medicare will therefore remain a budget target, even more so if Catastrophic Care "budget neutrality" proves to be a farce.**

Medicare's size is not the only issue -- its rate of growth has been faster than any other major federal program. Medicare has consistently grown more quickly than Social Security, national defense, and the entire U.S. budget. Moreover, this pattern of rapid growth is expected to continue.

As a consequence, Medicare has been taking an increasing share of federal outlays. It accounted for 5% of federal outlays in 1977. Today, it accounts for 8%, and by 1993, it is likely to consume 11% of all federal expenditures. In an era of massive federal budget deficits, these facts alone are enough to call attention to the Medicare program.

All five of Congress' recent "budget reconciliation" bills contained Medicare budget cuts. Carol McCarthy, president of the American Hospital Association, claims that "Medicare has contributed more than its annual fair share to deficit reduction." She notes that the Medicare program "sustained 36% of the outlay cuts made to meet goals for reducing the federal deficit for fiscal 1988."

The reason that Medicare appears to have taken such a "disproportionate" share of recent budget cuts is simple: former President Reagan and the 100th Congress decided little could (or should) be done about interest payments on the national debt or about Social Security or (to a lesser degree) national defense outlays. Because these "exempt" programs account for 62% of total federal outlays, eking out billions of dollars worth of budget cuts from the remaining federal programs was an extremely difficult political task.

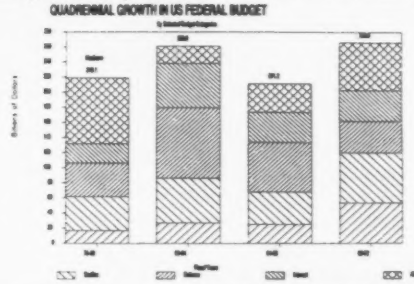
In this political context, the Medicare program stands out. When interest, national defense, and Social Security outlays are placed "off limits," the Medicare program accounts for one-fifth of remaining outlays and is destined to account for more than one-quarter of remaining outlays within a few years.

Moreover, as long as Americans seek to balance the federal budget without new taxes, the focus of attention will be on controlling the growth of federal outlays. Given this political objective, Medicare is especially vulnerable.

During the past four years (FY 1984-88), four items -- interest, Social Security, defense, and Medicare -- accounted for 82% of the $211 billion growth in total federal outlays. In the next quadrennial (FY 1988-92). Based on U.S Congressional Budget Office (CBO) projections, these same four items are expected to account for 76% of the $266 billion growth in total federal outlays.

Both Social Security and national defense are heavily defended politically. Major changes in interest outlays are unlikely in the short run. Thus, budgetary restraint inevitably shifts to Medicare -- a single target that represents nearly one-half of the remaining growth in federal outlays.

Furthermore, if Medicare enrollees are largely protected from sharing in the increasing costs of their benefits, then Medicare outlays to health-care providers will bear a disproportionately large share of the burden of balancing the federal budget.



Reagan's Legacy: PPS Controls Part A, But Part B Balloons

During the Reagan Administration, budget deficits were used as a lever to curtail the growth of many federal programs. Many reductions were implemented in the Medicare program, including:

- Provider payments were limited;
- Medicare beneficiaries were required to pay for more of their care through higher co-payments, deductibles and premiums, and
- A portion of the federal government's underwriting risk for the Medicare program was shifted to health maintenance organizations (HMOs), competitive medical plans (CMPs) and employers.

While the significance of these changes cannot be understated, the hallmarks of the Reagan Administration's health initiatives were the conception and nurturing of two extraordinary pieces of legislation that will influence the direction of the Medicare program for many years to come. First, a revolutionary Prospective Payment Program (PPS) -- aimed at controlling the cost of inpatient hospital services -- was activated. Second, in a major drive to accommodate the needs of the elderly, coverage was extended for "catastrophic" care.

During the first 22 years of the Medicare program, hospitals were reimbursed (subject to certain limits) on the basis of their incurred costs for their services provided to Medicare beneficiaries. This open-ended, retrospective cost-based payment mechanism was widely criticized as being inherently inflationary.

In a radical departure from prior policies, a bold new initiative was implemented in October 1983. Under PPS, Medicare sets a fixed price per admission for hospital services based on classifying patients into one of more than 400 mutually-exclusive diagnosis-related groups (DRGs).

Because hospitals were suddenly faced with a whole new ball game, they and their medical staffs had to drastically alter their thinking about how they handled the diagnosis and treatment of Medicare patients. After only four years in operation, PPS has had a substantial effect on not only hospitals but also the entire American health care industry.

Hospital admissions of Medicare patients dropped by more than 2% per year. The average length of stay for elderly hospitalized patients fell to 8.9 days in 1987, down from 10.2 days in 1982.

Offsetting these remarkable declines in inpatient hospital utilization were equally remarkable advances in the volume of care provided in outpatient, physician office, hospice, home health, and medical clinic

settings.

It is debatable as to whether or not this enormous change in where health care services are performed achieved any real savings. What is clear is the rate of growth in Medicare Part A outlays fell dramatically after 1985 while the rate of growth in Medicare Part B outlays grew precipitously. More specifically, while the rate of growth in Medicare outlays for hospital inpatient services dropped, the rate of growth in Medicare outlays soared for hospital outpatient services , group practice plans and physician services.

As a consequence, Medicare's outlays shifted from hospitals to physicians. In the late 1970s, about 73% of all Medicare expenditures were for hospitals services, 23% were for physician services, 2% for home health agencies (HHAs), and the remainder for nursing home and independent laboratories. By FY 1986, 66% went to hospitals, 29% to physicians, 3% to HHAs, and the remainder to labs and hospices.

Collectively, these changes resulted in a decline in Part A of the Medicare program relative to Part B. Accompanying this shift, politicians' attention to Part B matters increased. But before turning to this, let us first examine Reagan's other landmark piece of health legislation.

Catastrophic Care Extension Opens Another Can Of Worms

In the early summer of 1988, the 100th Congress overwhelmingly voted in favor of adopting the Medicare Catastrophic Coverage Act. This historic legislation represents the first major expansion in the Medicare program since 1972.Effective January 1, 1989, Congress agreed to:

- provide unlimited "free" acute hospital care to all Medicare beneficiaries (after one $560 annual deductible),
- expand coverage of care in a skilled nursing facility (SNF) to 150 days per year, up from 100 days per year,
- drop the previous minimum 3-day prior hospital stay that had been required for SNF benefits,
- eliminate all hospital co-insurance payments and limit the hospital deductible to only one per year instead of one per admission.

In addition, effective January 1, 1990, legislators agreed to:

- cap enrollees' Part B copayment costs (in 1990, the cap will be $1,370) and
- increase home health benefits to 38 days from 21 days.

Also effective January 1, 1990, they agreed to add three entirely new benefits: screening mammography for women, respite care (up to 80 hours per year), and drugs administered intravenously at home (subject to a 20% co-payment).

Finally and most significantly, effective January 1, 1991, they agreed to expand Medicare's coverage to include, for the first time, outpatient prescription drugs and insulin (subject to a $600 deductible and a 50% co-payment in 1991, a 40% co-payment in 1992, and a 20% co-payment in 1993 and subsequent years).

In light of major Congressional efforts over nearly two decades to control Medicare spending and in light of the fact that more than two-thirds of all Medicare beneficiaries already had coverage for most of these items through supplementary private health insurance (i.e., "Medigap") policies, the 1988 Catastrophic Coverage Act is a remarkable piece of legislation.

According to the CBO, the Medicare Catastrophic Act will cost more than $30 billion during the next five years alone. In the face of massive budget deficits, how could Congress justify this $30-billion "gift" to the nation's elderly?

In a major break with prior Medicare policies, this $30-billion tab is to be financed entirely by enrollees' premiums. Thus, in its sponsors' eyes, the Catastrophic Act is "budget neutral" -- i.e., new federal government revenues (i.e., taxes) will cover all new expenses so that there will not be any increase in the federal deficit. Whether the program will in fact remain budget neutral as it unfolds is a matter of debate. Certainly, past experience with federal reimbursement indicates this is unlikely.

Effective January 1, 1989, the Part B premium for Medicare enrollees will be $31.90 per month, up 28.6% over 1988. In addition, for the first time, Congress added a "means test" to the Medicare program: all Part A enrollees with annual income tax liabilities in excess of $150 will have to pay a 15% income surtax (i.e., a tax on tax liability) up to a maximum amount of $800 in 1989, scaling up to $1,050 in 1993.

This income surtax will affect about 36% of all Part A enrollees, or about 10 million Americans. For these individuals, the cost of the new catastrophic benefits will exceed their value. On the other hand, elderly citizens who have annual incomes of less than $14,000 will benefit financially.

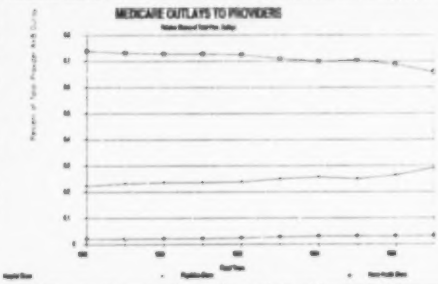
When Medicare beneficiaries start paying for these expanded benefits, there could be a political backlash, and Congress may be forced to dip once again into the general revenue pool to support the Medicare program.

Physician Payments On The Block; The Hsiao Report Is Out

With the rapid rise in Medicare Part B payments to physicians, this might logically appear to be the next target for cost-containment efforts. Indeed, there are many signs to support such a case. The Physician Payment Review Commission (PPRC), created by Congress in 1985, has been busily at work for two years developing what it calls "An Agenda for Reform."

The Health Care Financing Administration (HCFA) has underwritten a large-scale multiple-year study by Dr. William Hsiao of Harvard University of a resource-based relative-value scale (RBRVS) that might be used in implementing physician payment reform.

In a recent statement, Dr. Hsiao asserted that "there is a growing consensus that the prevailing method of paying for physicians' services should be fundamentally reformed. Increasingly, physicians, patients and insurers find the current system based on usual, customary and reasonable charges to be cumbersome and administratively complex."



While there is certainly some truth in what Dr. Hsiao says, Dr. William Roper, HCFA's Administrator (expected to be replaced by a Bush appointee soon), points out that a movement to a RBRVS will "only reallocate physicians' fees, leaving the longstanding problem of the rapid growth in the volume and intensity of physician services largely unresolved."1

Indeed, PPRC analysis of Medicare Part B approved charges between 1975 and 1985 shows that over 40% of the increase in Part B outlays is the result of rising volume of services per enrollee (see Figure 12). But in spite of this finding, much of PPRC's work has been devoted to the development of a Medicare fee schedule (that may or may not be based on RBRVS).

While a fee schedule could be effective in controlling the price that Medicare pays for physicians' services, it is unlikely to suppress the volume of services rendered to Medicare beneficiaries by physicians.

In conclusion, to understand why the Medicare program has become one of the great political enigmas of our time, one must recognize that it is wrapped up in a host of other complex and controversial national problems.

Lynn Etheredge, former health staff director at the U.S. Office of Management and Budget (OMB) in 1978 to 1982, explains why Medicare reform will be so difficult to achieve. He says, "the Medicare program's future is integrally linked with three of the most difficult problems which now confront public policy for the years ahead:

- the federal budget deficit,
- the inflation of health-care costs, and
- the needs of a growing retired population."

As Etheredge sees it, "the Medicare program... ties these problems together -- and thus multiplies the consequences (and the difficulties) of enacting reforms in each area, and in the Medicare program."

By the mid-1990s, outlays for the hospital insurance (HI) portion of the Medicare program (commonly called "Part A") may exceed payroll tax receipts. As a consequence, the Federal Hospital Insurance Trust Fund's current reserves of approximately $70 billion will begin to wither away. Unless prior action is taken, by the end of the twentieth century, the HI Trust Fund faces the prospect of bankruptcy.

The magnitude of the projected actuarial deficit in the HI program and the probability that the HI trust fund will be exhausted around the turn of the century is a serious matter. Its Board of Trustees concluded in their spring 1988 report to Congress that "early corrective action is essential in order to avoid the need for later, potentially precipitous changes."

In many ways, the fiscal problems of the supplementary medical insurance (SMI) portion of Medicare (commonly called "Part B") are even grimmer than the HI program's problems. In FY 1978, SMI disbursements were $7.3 billion. Four years later, in FY 1982, they had doubled to $15.6 billion. And five years later, in FY 1987, they had doubled again to $30.8 billion.

During the last five years, the SMI program grew 40% faster than the economy as a whole. Moreover, its Trustees indicate "this growth rate shows no sign of abating despite recent efforts to control the cost of the program."

In contrast to Part A which is financed by payroll taxes, Part B is financed by a combination of premiums paid by SMI's 31 million enrollees (which in recent years accounts for nearly one-quarter of SMI's income) and general revenue contributions from the U.S. Treasury (which pays for more than 75% of SMI's costs).

As the looming problems of the Medicare trust funds become increasingly apparent and a "crisis" atmosphere develops, President Bush and/or the 101st Congress are likely to act. If and when a political or financial crisis occurs, the next array of changes in the Medicare program might make PPS look pale in comparison. In the meantime, there is a high probability that politicians will find tinkering with Medicare to be irresistible.

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Written Testimony Before the
Senate Finance Subcommittee
Medicare and Long-Term Care
Overview of Medicare Program
March 3, 1989

by the

Health Policy Coalition
Charles Weller,
Jones, Day, Reavis & Pogue

HEALTH POLICY AT THE CROSSROADS

I. Facts

1. The United States spends more on health care than any country in the world -- with 37 million people uninsured. (Attachment 1).

2. 100% of GNP, given current trends, will be spent on medical care in 45 years. EBRI, Measuring and Funding Corporate Liabilities for Retiree Health Benefits (1982).

3. Medicaid now covers less than 40% of the poor. It covered nearly 70% 12 years ago. (Attachment 2).

4. There is convincing medical evidence that there are wide variations in medical practice patterns with largely unknown correlations to patient outcomes. (Attachments 3 & 4). It has been estimated that on the order of $100 billion is spent annually on ineffective or marginally effective health care services. Dr. Eugene Robin, Stanford University, National Underwriter (March 9, 1987).

5. About 80% of all public and private health insurance programs still provide doctors and hospitals with disincentives, rather than positive incentives, to deliver affordable quality health care. (Attachment 5).

6. Employees generally have little say in how their health care dollars are spent, as they generally are under the illusion that it is "free." In reality, employee health insurance costs largely represent lost wages. (Attachment 11) (enclosed).

II. The Current Road to Escalating Costs

1. Most pending health care legislation focuses on new financing gimmicks, and ignores the opportunity to purchase health care with positive incentives for value.

   -- Stark Risk-Pooling Bill

   -- Kennedy mandated health insurance bill, which mandates benefits irrespective of cost.

-- Medicare long-term care coverage, with the elimination of FICA $45,000 ceiling and other new financing techniques.

2. Doctors, hospitals and patients face an escalating trend towards "command and control" regulation of medical practice by both public and private payors. (Attachment 6).

3. Major legislative proposals such as various mandated health insurance bills will rigidify and politicize health benefits at the time of the greatest experimentation in health benefits in history.

III. The New Road Less Traveled: The Pursuit of Value

A. Principles of Opportunity.

1. Focus on providing doctors and hospitals with positive incentives, rather than disincentives, to deliver quality health care at affordable cost. Positive incentives now account for only about 20% of all health care spending, so the opportunity is vast. New financing programs that perpetuate these disincentives will undermine health care benefits for the elderly, working people and the poor. (Attachment 5).

2. Increase consumer involvement in obtaining the best value for their dollars. Consumer involvement is now uncommon. (Attachment 11) (enclosed).

3. Provide patients, doctors and hospitals with information on the efficacy of medical procedures. Dr. Wennberg and others have identified a major opportunity as well as need to improve what is known about efficacy. (Attachment 4).

4. Identify public and private success stories, and provide incentives to incorporate them in public and private programs including Medicare and Medicaid. (Attachment 12).

B. Sample Success Stories and Ideas For Action.

1. Ameritrust -- joint employee/employer/provider programs that use positive incentives with doctors, hospitals and employees. Result: expanded benefits, and little if any increase in costs in 1988. (Attachment 7).

2. Greater Cleveland Growth Association/COSE program for small employers -- the Small Employers Health Insurance Availability and Affordability Act. (Attachment 8).

3. Section 89 -- modify Section 89 to simplify experimentation with more effective, and vastly less burdensome, means of providing health insurance to uninsured workers.

4. The Patient Outcome Assessment Research Program authorized under 42 U.S.C. Section 139511(c) -- fully fund in the current and future appropriations process this innovative and much needed research program. (Attachment 9).

5. California Competitive Bidding Program -- provide incentives for the expansion of the California competitive bidding program for hospital care for Medicaid recipients to other states. (Attachment 12).

6. Harvard Community Health Plan -- implement positive incentives for doctors to perform and deliver quality care. (Attachment 6).

Attachments (available on request)

1. Total Health Expenditures as a Proportion of Gross Domestic Product.

2. Medicaid Coverage, 1976-1984.

3. Rice, "Do We Get Full Value for Our Health Care Dollar?"

4. Wennberg, "Improving the Medical Decision-making Process."

5. Weller, Postive Provider Incentives Index.

6. Dr. Berwick, Harvard Community Health Plan, testimony.

7. Osenar & Bowers, "The Taming of Health Care Costs."

8. Health Policy Coalition, Small Employer Health Insurance Affordability and Availability Act.

9. Patient Outcome Assessment Research Program.

10. Weller, "Rx for the Costly Epidemic of Health Care Legislation," Wall Street Journal (May 8, 1988).

11. Workers' Silent Payroll "Taxes" for Health Care.

12. Melnick & Zwanziger, "Hospital Behavior Under Competition and Cost-Containment Policies," 260 JAMA 2669 (Nov. 11, 1988).

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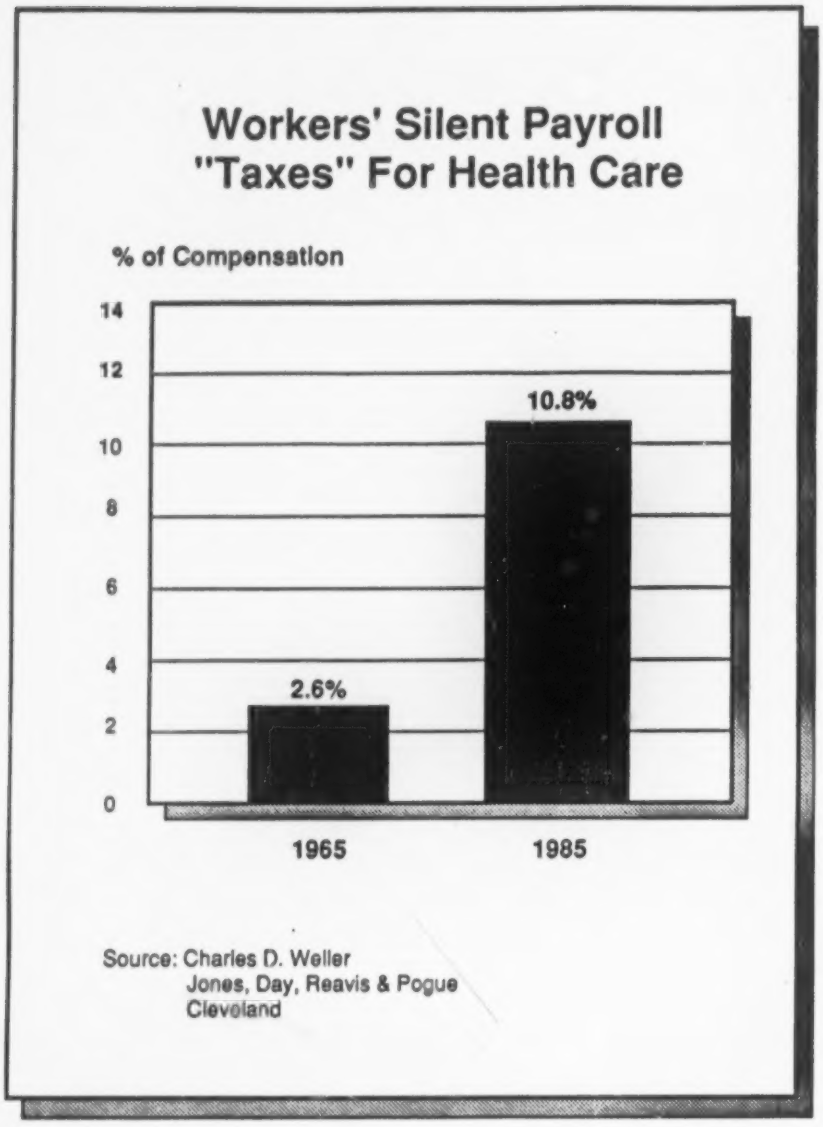
Workers' Silent Payroll
"Taxes" For Health Care
% of Compensation
14
12
10
8
6
4
2
0
10.8%
2.6%
1965
1985
Source: Charles D. Weller
Jones, Day, Reavis & Pogue
Cleveland